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# Multifaceted Traumatization: Direct and Vicarious Exposure of EMS Personnel Who Responded To a Suicide Where Loved Ones of the Deceased Were Present

Mallory Rae Wines

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MULTIFACETED TRAUMATIZATION: DIRECT AND VICARIOUS EXPOSURE OF EMS  
PERSONNELWHO RESPONDED TO A SUICIDE WHERE LOVED ONES OF THE  
DECEASED WERE PRESENT

A Dissertation

Submitted to the School of Education

Duquesne University

In partial fulfillment of the requirements for  
the degree of Doctor of Philosophy

By

Mallory Wines

May 2016

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Mallory Wines

2016

**DUQUESNE UNIVERSITY**  
**SCHOOL OF EDUCATION**  
**Department of Counseling, Psychology and Special Education**

***Dissertation***

Submitted in Partial Fulfillment of the Requirements  
For the Degree of Doctor of Philosophy (Ph.D.)

**Executive Counselor Education and Supervision Program**

***Presented by:***

Mallory Wines, M.S.Ed

**March 7, 2016**

**MULTIFACTED TRAUMATIZATION: DIRECT AND VICARIOUS EXPOSURE OF EMS  
PERSONNEL WHO RESPONDED TO A SUICIDE WHERE LOVED ONES OF THE  
DECEASED WERE PRESENT**

***Approved by:***

\_\_\_\_\_, Chair  
Debra Hyatt-Burkhart, Ph.D  
(Professor)

\_\_\_\_\_, Member  
Lisa Lopez Levers, Ph.D  
(Professor)

\_\_\_\_\_, Member  
Waganesh Zeleke, Ed.D  
(Professor)

## ABSTRACT

# MULTIFACTED TRAUMATIZATION: DIRECT AND VICARIOUS EXPOSURE OF EMS PERSONNEL WHO RESPONDED TO A SUICIDE WHERE LOVED ONES OF THE DECEASED WERE PRESENT

By

Mallory Wines

May 2016

Dissertation supervised by Dr. Debra Hyatt-Burkhart

Emergency medical services (EMS) personnel experience direct traumatic exposure that can leave a lasting negative impact. However, little is known about the vicarious exposure that EMS personnel experience at challenging calls when family and loved ones are present at the scene. Additionally, there is minimal research that has looked at the experiences among paramedics and EMT's who arrive to mental disturbance calls or completed suicides. In order to add to the substantial body of literature on EMS personnel and traumatic exposure, this study explored their experiences of multifaceted traumatization; the lived experiences of paramedics and EMT's who have responded to completed suicides where loved ones of the deceased were present, and as a result, experienced both a negative psychological impact and posttraumatic growth. The study explored the risk factors and protective factors that paramedics and EMT's experience in their work. Additionally, this inquiry sought to explore the ways in which

participants find meaning in providing emergency medical services and how they sustain their work.

This qualitative, phenomenological study was conducted through semi-structured individual interviews with 12 paramedics or EMT's who have been employed or volunteered for at least one year. Explication of data was completed using van Manen's (1990) four existential themes: spatiality, corporeality, temporality, and relationality. The results of this study identified themes that address van Manen's (1990) lived existentials, protective factors against posttraumatic symptoms through direct and vicarious traumatization, risk factors that contribute to these symptoms, and meaning making in their work. The implications of the study for the field of emergency medical services and suggestions for future research are provided.

## DEDICATION

This dissertation is dedicated to my Poppy. I miss you always! This is for you.

## ACKNOWLEDGEMENTS

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## **Chapter 1: The Problem**

### **Introduction**

The impact of traumatic life events and the reaction thereof varies among individuals, but some experience significant emotional, psychological, and physical effects. For most, the emotional distress diminishes over time, but for some, the effects can greatly impact their emotional well-being. “Traumatic events can have profound effects on the individuals who experience them, and the impact of such stressful events or circumstances usually results in people feeling overwhelmed, vulnerable, betrayed, helpless, frightened, and alone” (Levers, 2012, p.1). Research has focused on the negative effects of exposure to trauma and it has been explored in the literature for many years (Shakespeare-Finch, Smith, & Obst, 2002; Turnbull, 1998). Traumatic exposure is examined in this qualitative study to better understand people who are directly exposed to trauma in their everyday lives as emergency medical services (EMS) personnel.

Much of the research that has been conducted on traumatic exposure has focused on the psychological functioning of trauma-exposed individuals. Research topics have included factors that contribute to the development of stress-related disorders (Beaton, Murphy, Pike, & Cornell, 1998; Briere & Scott, 2013), support and debriefing mechanisms following trauma exposure (Kleim & Westphal, 2011; Prati & Pietrantonio, 2010; Ussery & Waters, 2006), crisis interventions to assist in returning to normal functioning (Mitchell & Everly, 1986; 2000), and most recently, positive psychological approaches and posttraumatic growth (Chopko & Schwartz, 2009). These factors are important to this study and are discussed in-depth in the following chapters.

In addition to the psychological effects from direct traumatic exposure, individuals can also experience similar effects from vicarious traumatic exposure (Figley, 1985; 1995; 2002a; McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995).

Vicarious traumatization is defined as the psychological effects resulted from indirect exposure to traumatic events (Palm, Polusny, & Follette, 2004). This focus on vicarious exposure is a more recent area of study among researchers and these experiences have been shown to be just as stressful as direct exposure to trauma (Figley, 1985; 1995; 2002a, McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). In addition to the term “vicarious traumatization,” other terms have been coined to describe this phenomenon, such as burnout (Maslach & Jackson, 1981) and compassion fatigue (Figley, 1995).

Of special concern are the professionals who experience traumatic exposure while providing direct aid to trauma survivors, such as EMS personnel or first responders (Grevin, 1996; Mitchell & Dyregrov, 1993; Shakespeare-Finch, et al., 2002). “First responders are those individuals who, in the early stages of an accident or disaster, are responsible for the protection and preservation of life, property, and the environment” (Prati & Pietrantonio, 2010, p. 403). EMS personnel and first responders include paramedics, emergency medical technicians, firefighters, police officers, crisis response teams, and search and rescue teams. For the purposes of this study, the focus is on certified paramedics and EMT’s.

EMS personnel must meet specific criterion in order to become a certified EMT or paramedic. The National Registry of Emergency Medical Technicians (NREMT), indicates that the following criterion must be met in order to achieve certification: must be at least 18 years of age, pass an EMT course, and pass a criminal background check (NREMT, 2015). Emergency medical personnel have titles based upon their level of education and training (NREMT, 2015).

There are four levels of training including emergency medical responder, emergency medical technician, advanced emergency medical technician, and paramedic (NREMT, 2015). All levels of care provide lifesaving care to patients with critical concerns (NREMT, 2015). Emergency medical responders have the basic knowledge and skills to initiate emergency care while awaiting for additional EMS personnel to arrive to the scene (NREMT, 2015). Emergency medical technicians (EMT) hold the basic knowledge and skills, and provide basic emergency medical interventions and transportation to the emergency medical system with equipment typically found on an ambulance (NREMT, 2015). The advanced EMT is similar to the EMT but can provide basic and limited advanced emergency medical care and transportation (NREMT, 2015). Paramedics provide advanced emergency medical care to critical patients and their training includes complex knowledge and skills necessary to provide advanced patient care and transportation (NREMT, 2015).

Despite the initial and continued training among EMS personnel, first responders are more likely to experience negative psychological effects due to continued direct medical care and traumatic exposure. These negative effects may include stress-related symptoms, psychiatric disorders, and physiological symptoms (Benedek, Fullerton, & Ursano, 2007; Prati & Pietrantonio, 2010). The development of The Diagnostic and Statistical Manual (DSM), a manual covering all psychiatric illnesses, has evolved to include stress related disorders, such as posttraumatic stress disorder (PTSD), which is further reviewed in the following chapters.

Like many professional fields who directly work with trauma-exposed individuals, EMS personnel may also experience vicarious traumatic exposure during their duties as an emergency medical responder (Tracy, 2012). During EMS personnel's responses to traumatic events, vicarious exposure may be experienced if loved ones are present at the scene. Aside from the

research conducted on the presence of loved ones during medical interventions (Ellison, 2003; Fernandez, Compton, Jones, & Velilla, 2009; Madden & Condon, 2007), little research has been conducted to examine the presence of loved ones at other trauma scenes. The research that has been conducted on the presence of loved ones during medical interventions has explored the thoughts and feelings among the medical providers and loved ones themselves (Williams, 2002). The literature suggests that further research is needed to understand the effects upon helpers that experience family presence at other types of traumatic events, such as mental disturbance calls and completed suicides.

While EMS personnel respond to accidents and disasters, they are also contacted to respond to mental disturbance calls, including individuals who present with suicidal ideations, suicide attempts, and completed suicides. About one third of all EMS calls are mental disturbance calls related to suicide attempts or individuals presenting with suicidal ideations (Shaban, 2006), some of which are completed suicides (Koch, 2010). With an estimated 800,000 suicide completions each year, suicide continues to be a concern among all populations (WHO, 2016) and EMS are often contacted to respond to suicide attempts and for retrieval of the deceased (Kleim & Westphal, 2011).

There is voluminous research on the negative psychological effects to exposure to trauma, but there are gaps in the literature that still exist. There is minimal research conducted on EMS personnel's direct exposure of arriving to mental health related calls, such as completed suicides. In addition, there is minimal research designed to develop an understanding of EMS personnel's experiences of vicarious exposure where loved ones are present at traumatic scenes. Therefore, this qualitative study looks at the experiences of paramedics and EMT's who respond

to scenes of completed suicides with loved ones of the deceased present. This study provides an opportunity to look at the combination of direct and indirect experiences of traumatic exposure.

### **Defining Trauma**

For the purposes of this qualitative study, which focuses on the direct and vicarious traumatic exposure experiences of emergency medical responders, the definition of trauma is defined in accordance with criterion for PTSD in the Diagnostic and Statistical Manual of Mental Disorders (DSM), 5<sup>th</sup> edition (American Psychiatric Association, 2013):

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (American Psychiatric Association, 2013, p. 280).

### **Effects of Traumatic Exposure**

Research has focused on the negative psychological symptoms experienced from traumatic exposure. The psychological symptoms experienced during the traumatic event are known as “traumatic stress reaction,” while posttraumatic stress reactions are the emotions experienced following the traumatic event (Figley, 1985). Various factors can contribute to the emotional responses that traumatic exposure can have on individuals. These factors include the type of traumatic event, the frequency of traumatic exposure, severity of the event, victim-

specific factors, and psychosocial considerations (Briere & Scott, 2013). The reaction may vary among individuals, and some may meet the criteria for stress disorders, such as PTSD, acute stress disorder, adjustment disorder, and mood disorders, which are further discussed in chapter two.

Van der Kolk & McFarlane (1996) describes the psychological effects of traumatic exposure as follows:

Despite the human capacity to survive and adapt, traumatic experiences can alter people's psychological, biological, and social equilibrium to such a degree that the memory of one particular event comes to taint all other experiences, spoiling appreciation of the present (pg.4).

### **Negative Effects of EMS Traumatic Exposure**

The role of an emergency medical responder is to assist individuals in the early stages of an accident or disaster (Prati & Pietrantonio, 2010). Due to the on-going exposure of traumatic events, EMS/first responders are at risk of experiencing a range of physical health and mental health consequences (Benedek, et al., 2007; Briere & Scott, 2013; Regehr, et al., 2002; Ussery & Waters, 2006; Williams, et al., 2008). Physical health symptoms include digestive disorders, respiratory ailments, cardiovascular disease, and cancer (Ussery & Waters, 2006). Mental health symptoms include sleep disturbances, substance abuse, poor job performance, and increased risk of accidents (Ussery & Waters, 2006). Research suggests that physical and mental health symptoms can be long-term and that repeated exposure can lead to depression, substance abuse, and PTSD (Regehr, et al., 2002).

One primary concern of exposure to traumatic events is the risk of developing symptoms of posttraumatic stress disorder (PTSD). Van der Kolk & McFarlane (1996) indicates "The



posttraumatic syndrome is the result of a failure of time to heal all wounds” (p. 7). According to the American Psychiatric Association (2013), a diagnosis of PTSD may be given when a person has been exposed to a traumatic event and thus experiences negative psychological symptoms. An individual must have experienced, witnessed, or have been confronted with a traumatic event(s) that involved a serious threat to self or others and must have involved intense fear, horror, and feelings of helplessness (American Psychiatric Association, 2013).

Due to their continuous exposure to traumatic events, research has concluded that a diagnosis of PTSD is more prevalent among first providers than the general population (Carlier, Voerman, & Gersons, 2000; Clohessy, Ehlers, & Anke, 1999; Perrin, DiGrande, Thorpe, Farfel, & Brackbill, 2007; Regehr, et al., 2002). The rate of developing PTSD following traumatic exposure among the general population is around 4% (Kleim & Westphal, 2011) whereas the literature has shown much higher rates among first responders. Clohessy & Ehlers (1999) concluded that 21% of ambulance workers in their study met criteria for PTSD. Another study of this same population indicated a 12% rate of severe post-traumatic symptoms (Van der Ploeg & Kleber, 2003), while a study conducted by Regehr, et al. (2002) concluded that over 25% of first responder participants met criteria for the “higher or severe range” of PTSD. These higher rates of PTSD are concerning and certainly merit further inquiry into the factors that may create such disturbance and how these factors may be mitigated.

There are potential risks in the emergency medical services field and it is important for EMS to be aware of potential challenges that they may face. Being a member of the helping profession can impact one’s own emotional stability and health, and there has been a great amount of literature that describes this ‘cost to caring’ (Figley, 1995; Gentry, 2002; Maslach & Jackson, 1981; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The research on

symptoms of burnout, compassion fatigue, and vicarious traumatization is discussed below and further explored in chapter two.

### **The Cost of Caring**

There is a vast amount of literature that explores the secondary traumatization of personnel in the helping profession. The symptoms connected to the emotional response of caring for others can ultimately impact personal lives, careers, and family relationships (Gentry, 2002). Many definitions and terms have been proffered to describe the experiences among helpers, but for the purposes of this study and clarity, I'll limit this review to the following terms: "burnout" (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2002), "compassion fatigue" (CF) (Figley, 1995; Pearlman & Saakvitne, 1995), and "vicarious traumatization" (VT) (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

#### **Burnout**

Researchers began to explore the phenomenon of burnout in the 1970's (Maslach, et al., 2001). Burnout is the emotional exhaustion and depersonalization that occurs frequently among individuals in helping professional fields (Maslach & Jackson, 1981). Burnout is measured by three factors: emotional exhaustion, depersonalization or cynicism, and negative self-evaluation/lack of accomplishment (Maslach & Jackson, 1981; Maslach, et al., 2001). Research has shown that those in helping professions, such as therapists and counselors, are more likely to experience symptoms of burnout due to the continuous empathy provided to traumatized clients and the resultant increased possibility of emotional exhaustion (McCann & Pearlman, 1990).

#### **Compassion Fatigue**

Compassion fatigue was initially defined by Figley (1995) as "the natural behaviors and emotions that arise from knowing about a traumatizing event experienced by a significant

other—the stress resulting from helping or wanting to help a traumatized person” (p. xiv).

Individuals suffering from CF tend to be those who are highly motivated to improve the resiliency of their clients (Gentry, 2002). Symptoms of CF are manageable and treatable (Pearlman & Saakvitne, 1995) and Gentry (2002) encourages helpers to seek interventions when presented with symptoms of CF, “With skilled intervention and determination, care providers with compassion fatigue can undergo a profound transformation leaving them more empowered and resilient than they were previously, and therefore better equipped to act as “givers of light” (p. 29).

### **Vicarious Traumatization**

Almost an extension of the concept of CF, vicarious traumatization is a more recent area of focus among researchers. Vicarious traumatization is defined as the psychological effects of indirect traumatic exposure (Palm, et al., 2004; Pearlman & Mac Ian, 1995; Pearlman, & Saakvitne, 1995). Workers in a variety of helping professions may experience vicarious traumatization including mental health professionals, emergency medical workers, and trauma workers. Significant stress-related symptoms are not limited to the victim alone, but studies suggest that stress symptoms also can be experienced by other individuals who witnessed the event, listened to details of the event, or had knowledge of the event (American Psychiatric Association, 2000; Erikson, Vande Kemp, Gorsuch, Hoke, 2002; Lerias & Byrne, 2003; Son, Singer, & Anglin, 1998). Brady, Guy, Poelstra, and Brokaw (1999) describe the experience of vicarious traumatization as similar to the experiences of those who had direct exposure to the traumatic event.

Although the meaning of vicarious traumatization and compassion fatigue are similar, there are differences that exist between these concepts. Compassion fatigue is directly related to

the cognitive schema of the therapist (Figley, 2002, p. 5). The emotional response experienced from the descriptions of traumatic events is defined as compassion fatigue. Rather, vicarious traumatization indicates the transformation of the “inner experience” in which the helping professional experiences from secondary traumatic exposure (Pearlman & Saakvitne, 1995). The effects of VT can alter one’s worldviews, beliefs about self and others, interpersonal relationships, and sense of meaning (Pearlman & Saakvitne, 1995).

### **Positive Effects of Trauma Exposure**

The literature has focused on the negative effects of traumatic exposure and the mechanisms that can be of aide. However, the potential for positive psychological changes and growth following traumatic exposure have recently gained attention by researchers (Tedeschi & Calhoun, 1995). There is a growing body of literature that indicates positive psychological consequences can occur as a result of traumatic events (Tedeschi & Calhoun, 1995). This positive perspective of traumatic exposure can provide the helping profession, such as EMS personnel, with a new perspective on coping with traumatic stress.

### **Posttraumatic Growth**

Healthy functioning among trauma-exposed individuals is a newer concept in the literature (Bonanno, 2004). Multiple terms are used to describe this phenomenon, such as perceived benefit (Affleck & Tennen, 1996), stress-related growth (Park, Cohen, & Murch, 1996), thriving (O’Leary, 1998), and more recently, posttraumatic growth (Tedeschi & Calhoun, 1995). These terms are highly related and over lapping in their definitions. Posttraumatic growth is described as healthy functioning and resiliency related to traumatic exposure and the corresponding opportunity for personal and professional growth (Tedeschi, Park, & Calhoun, 1998) which “...involves a movement beyond pretrauma levels of adaptation” (Tedeschi &

Calhoun, 2004, p. 4). The developing literature on posttraumatic growth suggests that “growth” is much more common than negative posttraumatic symptoms following traumatic exposure (Tedeschi & Calhoun, 2004). Posttraumatic growth is further explored in chapter two of this study.

### **Crisis Intervention**

In order to have a rounded understanding of traumatic exposure, it is important to understand the mechanisms that have been created in the hope of reducing the emotional impact of traumatic exposure and increasing the potential for posttraumatic growth among the study population. The exposure to traumatic events that emergency medical responders endure can have lasting effects, but crisis interventions have been developed to mitigate the impact that such exposure may have (Everly & Mitchell, 1999; 2000). Crisis interventions have been developed to increase healthy functioning, provide support, and assist individuals in returning to normal functioning following traumatic exposure (Everly & Mitchell, 1999; 2000). The following paragraphs provide a brief review of crisis intervention which is further reviewed in chapter two of this study.

Crisis intervention mechanisms were developed in the 1960’s and 1970’s to provide various support services to emergency medical providers (Mitchell & Everly, 2000). These interventions have evolved over the years to include a focus on services to helping professionals who experience stress-related symptoms (Mitchell & Everly, 2000). Crisis Incident Stress Management (CISM) is an intervention protocol developed to provide crisis support to helping professionals during the time of a crisis or immediately following (Mitchell & Everly, 1986). CISM programs have extended to other helping professional fields and are implemented through various techniques, which are discussed below.

CISD was established under the development of CISM interventions to alleviate post stress related symptoms and accelerate recovery following a traumatic event (Mitchell & Everly, 2000). Various forms of debriefing have been identified for emergency medical providers including internal and external forms of debriefing and can be implemented individually or in a group setting (Everly & Mitchell, 2000; Mitchell & Everly, 2000). Debriefing can be provided as an intervention by members of the same organization, or by external members of the organization, such as trained mental health professionals (Everly & Mitchell, 2000; Mitchell & Everly, 2000). Interventions such as stress management education, on-scene support, and crisis intervention support is implemented to alleviate the stress resulted from the traumatic event (Mitchell & Everly, 2000).

The literature on crisis intervention reveals that its effectiveness has been controversial. Many studies have shown significant positive effects following the use of formalized crisis intervention (Halpern, Gurevich, Schwartz, & Brazeau, 2008; Irving & Long, 2001; Leonard & Alison, 1999; Revicki & Gershon, 1996; Scully, 2011; Ussery & Waters, 2006), while other studies have concluded that the use of such formalized interventions create negative experience or that such interventions are, at least, ineffective (Addis & Stephen, 2008; Hobbs, Mayou, Harrison, & Worlock, 1996; Rick & Briner, 2000). Findings that indicate positive results from stress debriefing suggest that they produce a decrease in work stress (Revicki & Gershon, 1996), provide an opportunity for a “time-out” period following a crisis or exposure to a traumatic scene (Halpern, et al., 2008), and can result in a decrease in symptoms of PTSD (Scully, 2011). Studies that have indicated negative findings suggest the possibility of re-traumatization (Prati & Pietrantonio, 2010), higher rates of PTSD (Addis & Stephen, 2008), and poorer psychological health (Small, Lumley, Donohue, Potter, & Waldenstrom, 2000). These conflicting results make

the provision of debriefing interventions controversial and irresolute due to the lack of clarity surrounding the potential for benefit as well as harm.

### **Suicide**

This study sought to explore the experiences among EMS personnel who respond to completed suicides. In order to gain an understanding of the act of suicide, a review of suicide statistics is presented and further discussed in chapter two. Although statistics on suicide may never truly be accurate due to underreporting and stigmatization, organizations such as the World Health Organization (WHO, 2016) and The Center for Disease Control and Prevention (CDC), continue to collect annual statistics on suicide. The data collected revealed common themes among individuals who have attempted and completed suicide and is briefly reviewed in the following paragraphs.

Both the WHO (2016) and the CDC (CDC, 2015) indicate that over 800,000 people die by suicide each year, with an even larger number of individuals attempting suicide annually. The National Alliance on Mental Illness (NAMI, 2016) indicates that 30,000 individuals die by suicide each year within the United States alone (NAMI, 2016). Suicide has become one of the leading causes of death among all ages and groups (CDC, 2015; WHO, 2016). Overall, suicide accounts for 1.4% of all worldwide deaths and is the 15<sup>th</sup> overall leading cause of death in the United States (WHO, 2016). Specifically, suicide is the second or third leading cause of death among older adolescents and young adults (NAMI, 2016; Sudak, Maxim, & Carpenter, 2008; WHO, 2016), the second cause among adults between the ages of 25-34, the fourth cause among adults aged 35-54, and the eighth cause among adults aged 55-64 (CDC, 2015). The research suggests that females are more likely than males to have suicidal thoughts, but males are as much as four times more likely to complete suicide (CDC, 2015). Suicide rates are highest among

females between the ages of 45-54 and highest for males who are aged 75 and older (CDC, 2015).

Risk factors of suicide have been explored in the literature to identify characteristics that contribute to an increased likelihood that an individual will consider, attempt, or complete suicide. Risk factors may include biological, psychological, and social factors such as demographic factors, mental illness, alcohol and substance use, psychiatric treatment, suicide intent, family history, and one's support system (Motto, 1978). These risk factors are further reviewed in chapter two.

### **Suicide Survivors**

Survivors of suicide are identified as the family and friends who have lost a loved one to suicide (McIntosh, 1993; Smolin & Guinan, 1993; Sudak, et al., 2008). Suicide can have a profound effect among the family members and loved ones of the deceased. Not only do loved ones lose the physical presence of someone they deeply care about, but also a loss of the relationship they once had with that person (Bailey, Kral, & Dunham, 1999). Those individuals closest to the deceased suffer through the difficult grief process following the loss of their loved one. For every completed suicide, there is an estimated six to eight individuals who had significantly close relationships with that person, and suffer from the notion of 'complicated grief' (Berman, 2011; Smolin & Guinan, 1993). The literature identifies 'complicated grief' as the significant reaction that loved ones experience from the loss of a loved one to suicide (Bailey, et al., Mitchell, Kim, Prigerson, & Mortimer, 2005). Survivors of suicide may report feelings of abandonment, rejection (Bailey, et al., 1999), and guilt (Sudak, et al., 2008). In addition, survivors of suicide may be affected by the stigma and society's perception of suicide as a form of failure by the victim, the family, and loved ones (Cvinar, 2005). Survivors of suicide



may experience symptoms that are similar to the deceased such as depression, isolation from others, alcohol and substance use, and sleeping problems (Smolin & Guinan, 1993). Some studies indicate that some survivors may even experience suicidal ideations and attempts themselves (Bailey, et al., 1999; Mitchell, et al., 2005). Survivors of suicide may need significant support and positive coping abilities to grieve the loss of their loved one and to deal with the stigma around suicide (Cvinar, 2005).

### **Presence of Loved Ones**

For the purposes of this study, “loved ones” is identified as the family, friends, and others who have significant relationships with the deceased. As this study focuses on EMS personnel’s vicarious traumatic experiences of the presence of loved ones of the deceased at a completed suicide scene, a review of the literature on family presence is discussed. The phenomenon of family presence at various traumatic scenes and the impact of their presence upon first responders has been primarily overlooked by researchers. The research that has been conducted on the presence of loved ones has focused on emergency medical interventions, such as cardiopulmonary resuscitation (CPR) (Ellison, 2003; Fernandez, et al., 2009; MacLean, et al., 2003; Madden & Condon, 2007; Williams, 2002). There is limited research on the presence of loved ones during or following traumatic accidents, such as an automobile accidents or completed suicides. Some articles in peer-reviewed journals have mentioned the experiences that emergency medical responders describe of family and loved ones being present at the scene of traumatic events, but no research has been conducted on this experience. One article by Regehr, Goldberg, and Hughes (2002) mentioned paramedic’s reactions to the presence of loved ones, stating that they made “conscious efforts” to ignore the emotional reactions of loved ones at the

scene of traumatic events, but this theme was not further explored and was ancillary to their study.

The research on the presence of loved ones during medical interventions has been debated among participants in research studies. Some studies have found that the presence of loved ones during medical interventions is a positive experience (Maclean, et al., 2003; Madden & Condon, 2007; Williams, 2002) while other studies have identified some concerns (Ellison, 2003; Fernandez, et al., 2009; Madden & Condon, 2007). Positive experiences include increased communication between loved ones and medical providers (Ellison, 2003) and a better understanding on the part of loved ones regarding the interventions that are occurring at the scene (Madden & Condon, 2007). Some concerns regarding the presence of loved ones include, the possibility of breach of confidentiality and legal concerns, increased stress among emergency medical providers, and interference with necessary interventions (Ellison, 2003; Fernandez, et al., 2009; Madden, & Condon, 2007).

### **Statement of the Problem**

There is no question that emergency medical responders are exposed to traumatic events that include human suffering, pain, and death (Regehr, et al., 2002). EMS are routinely exposed to fatalities, they recover the dead or severely injured, provide emergency medical services to individuals who have just experienced a traumatic events, and work with loved ones of victims who have suffered from trauma (Kleim & Westphal, 2011). Such repeated traumatic exposure has been found to result in higher rates of stress-related disorders including depression (Regehr, et al., 2002), sleep disturbances (Fullerton, McCarroll, Ursano, & Wright 1992; Ussery & Waters, 2006), substance abuse (Ussery & Waters, 2006), and PTSD (Clohessy, Ehlers, & Anke, 1999; Perrin, et al., 2007; Regehr, et al., 2002). EMS also experience vicarious exposure to

trauma as witnesses to the traumatic events to which they respond. There is an ample amount of literature on the negative psychological effects of direct and vicarious traumatic exposure, but some phenomenon have been overlooked. There is minimal research on emergency medical responder's direct exposure to trauma when responding to completed suicides. In addition, there is no research that has explored EMS vicarious exposure to the traumatic experiences of loved ones of an individual who has committed suicide. This study explores this multifaceted traumatization: the direct exposure of responding to a completed suicide and the vicarious exposure of observing loved ones of the deceased who are experiencing their own direct traumatic exposure. The study provides an opportunity to look at the combination of direct and indirect experiences of traumatic exposure, and may provide a new direction for further research in multiple fields including emergency medical responders, mental health professionals, medical providers, and other helping profession fields.

### **Research Questions**

The research questions for this qualitative study were developed after a thorough review of the existing literature on the impact of traumatic exposure on emergency medical responders. Much of the existing literature has focused on the negative psychological effects that direct traumatic exposure has on EMS personnel. What has been overlooked is the focus on the multifaceted experiences of direct and vicarious exposure to traumatic events, such as completed suicides, where loved ones of the deceased are present. The guiding question for this qualitative study is: How do paramedics and emergency medical technicians experience responding to completed suicides where the loved ones of the deceased are present? The following subsidiary questions further guided the inquiry:

1. What are the lived experiences (lived space, lived body, lived time, and lived other) of EMS personnel when responding to suicides where loved ones of the deceased are present?
2. What risk factors are associated with EMS personnel as they respond to suicides where loved ones of the deceased are present?
3. What protective factors are associated with EMS personnel as they respond to suicides where loved ones of the deceased are present?
4. How do EMS personnel make meaning of their experiences of direct and vicarious exposure?

### **Significance of the Study**

The phenomenon of emergency medical responders direct exposure to completed suicides and the vicarious exposure to the presence of the loved ones of the deceased has not gained attention among researchers. These phenomena are an important part of understanding the experiences of emergency medical response personnel in their daily duties. A majority of emergency medical responders and other helping professionals are able to maintain emotional stability following continuous traumatic exposure (van der Kolk & McFarlane, 1996). However, the literature indicates that there is the possibility that emotional issues may arise for a percentage of professionals who work in fields with direct and indirect traumatic exposure (Regehr, et al., 2002). With greater understanding of multifaceted traumatization, opportunities could be developed for many fields, including first responders, mental health professionals, emergency medical providers, teachers and school employees, and others who are categorized under helping professional fields. These opportunities may include improved care to victims,

increased professional self-care, decreased turnover in helping professional fields, and improved critical incident debriefing and stress management interventions.

This qualitative study uses the lived experiences of employed and voluntary EMS personnel to gain rich details and interpretations of their experiences to better understand the phenomena of direct and vicarious exposure of responding to suicides with presence of loved ones of the deceased. This qualitative study is significant as it captures the daily events of EMS workers' life experiences. The significance of this qualitative study impacts several professional fields including emergency medical responders, crisis response teams, mental health professionals who provide care to EMS personnel and individuals with traumatic exposure/history, and other helping professional fields.

### **The Study**

In order to gain accounts of paramedics and EMT's direct and vicarious traumatic exposure as a consequence of arriving to completed suicides where loved ones of the deceased were present, a qualitative research design was used. A qualitative inquiry provides for an opportunity to understand this unexplored phenomenon and gather data to help illuminate the experiences among paramedics and EMT's. This study interviewed willing employed and voluntary EMS workers who have had direct traumatic exposure through attending to an individual who has completed suicide and, at the same time, have experienced vicarious trauma as a result of being exposed to the loved ones of the deceased at the scene. Semi-structured individual interviews were conducted with willing EMS personnel and these interviews were audio recorded. All data was transcribed in preparation for data explication, which was completed using van Manen's (1990) lived existentials: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relations (relationality),

## **Participant Selection**

For the purposes of this study, EMS personnel are identified as paramedics and EMT's who have at least one year of experience through employed or volunteer work. In order to study participants who have all experienced the phenomenon of interest, both criterion and snowball sampling methods were used. Creswell (2013) identifies criterion sampling as an effective method for studying people who all have experienced the same phenomenon, which is identified in this study as EMS personnel who have arrived to scenes of completed suicides where loved ones of the deceased were present. Berg (2007) identifies the second method, snowball sampling, as the method of receiving referrals to additional participants from current participants. In this study, participants who contacted me for participation were asked if they had knowledge of other participants who may have also experienced the phenomenon being studied. If referrals were suggested, I followed up with these potential participants through telephone calls.

In an attempt to recruit participants, phone calls were made to agency directors or supervisors of local ambulance companies in Ohio and Pennsylvania. I chose to recruit participants from multiple ambulance companies in order to gain perspectives and descriptions from professionally employed and volunteer EMS personnel from a variety of environments. I informed administrators of the following information from the informed consent: who I am as a researcher, the purpose of the study, what the interview entailed, what would happen with the results of the study, selection of participants, risks and benefits to participants, confidentiality, frequency and duration of interviews, and requests for audio recording of interviews. I emailed or took copies of the informed consent and recruitment letters and flyers to willing ambulance companies for potential participants to review. The recruitment letter and flyer included the

purpose of the study, who I am as a researcher, and my contact information with my phone number and email.

I reviewed the informed consent with willing participants when contact was made. Those participants who met study parameters (identified as an employed or volunteer paramedic or EMT and have worked or volunteered for at least one year, have responded to at least one suicide, and were over the age of 18) were asked to participate. I asked participants to meet for an individual interview at a private location of their choice, such as an office building, local library, or local university.

### **Data Collection**

Data were collected through the use of individual interviews, field notes, and analytic notes. An individual interview approach allowed participants to share their experiences of the phenomenon being studied with the researcher. By using a guiding question and follow-up subsidiary questions, a semi-structured interview approach was used for the individual interviews. The duration of individual interviews was approximately one hour, but time allotment was flexible for participants who required more time to completely respond to the questions. Individual interviews provided an opportunity for participants to describe their experiences, without the presence of other EMS providers, supervisors, or employees, whose observation of or participation in the interview may have restricted participant responses.

Field notes were also taken during individual interviews to capture expressions from participants and other non verbal data that would have been missed by audio recording. I expanded on these notes through reflection after each of the interviews was completed. I also used analytic notes, defined as ideas that occur to the researcher (Glesne, 2006), as part of data collection. As suggested by Glesne (2006), I wrote down my ideas in order to serve as a

reflection of my feelings, impressions, interpretations, and upcoming plans. After data collection was complete, all data was transcribed by me, read over multiple times, and provided to participants for accuracy. Van Manen's (1990) lived existentials guided the data explication process.

### **Theoretical Underpinning**

This hermeneutic phenomenological, qualitative study used van Manen's (1990) lived existentials as the theoretical underpinning. Van Manen (1990) describes phenomenology as "gaining a deeper understanding of the nature or meaning of our everyday experiences" (p. 9). Van Manen (1990) further describes, "phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience" (p.10).

Lived experience is the starting point and end point of phenomenological research. The aim of phenomenology is to transform lived experience into a textual expression of its essence—in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful: a notion by which a reader is powerfully animated in his or her own lived experience (van Manen, 1990, p. 36).

Van Manen's (1990) hermeneutic phenomenological approach is the foundation for this research study. The primary purpose of a phenomenological approach is "to reduce individual experiences with a phenomenon to a description of the universal essence" (van Manen, 1990, p. 177). I have chosen van Manen's (1990) hermeneutic phenomenological approach for the purposes of this research study to describe participants lived experiences. Van Manen (1990) identifies six research activities for research purposes (p. 30-31):

- (1) turning to a phenomenon which seriously interests us and commits us to the world;
- (2) investigating experience as we live it rather than as we conceptualize it;



- (3) reflecting on the essential themes which characterize the phenomenon;
- (4) describing the phenomenon through the art of writing and rewriting;
- (5) maintaining a strong and oriented pedagogical relation to the phenomenon;
- (6) balancing the research context by considering parts and whole.

In this research study, the *phenomenon* is identified as EMS personnel who have responded to completed suicides where loved ones of the deceased were present. The four existential themes identified by van Manen (1990) — lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relations (relationality), are used for data explication.

Van Manen's (1990) lived existentials are used as a guide for reflection in the research process. *Lived space (spatiality)* is one of the existentials identified by van Manen (1990) and is described as the sense of "home" in which individuals find themselves in; the "world" of the individual. For example, if you want to understand a person's world, you can ask about their profession or their background (van Manen, 1990). *Lived body (corporeality)* is described by van Manen (1990) as the "phenomenological fact that we are always bodily in the world" (p. 103). When meeting a new person, we meet them "through his or her body" (van Manen, 1990, p. 103). *Lived time (temporality)* is identified as the subjective time individuals experience, as opposed to actual clock time (van Manen, 1990). Van Manen (1990) states, "the temporal dimensions of past, present, and future constitute the horizons of a person's temporal landscape" (p. 104). The last existential, *lived other (relationality)*, in which van Manen (1990) describes as the space we share with other individuals. The presence the interaction has and the impression we develop is relationality (van Manen, 1990). The four existentials identified by van Manen

(1990) form an “intricate unity, which we call the lifeworld—our lived world” (p. 105). These existentials are used for reflection of the data and meaning found within individual responses.

### **Explication of Data**

Upon completion of the individual interviews, the student co-investigator transcribed the data collected, and then explicated all data including individual interviews, field notes, and analytic notes. In addition to van Manen’s (1990) four existentials, Groenwald (2004) suggests using Hycner’s (1999) five-step data explication process, which was also used in this study. This includes bracketing and reduction, delineating units of meaning, clustering units of meaning to create themes, summarizing interviews, and extracting themes.

### **Definitions**

**Acute Stress Disorder-** “The essential feature of acute stress disorder is the development of characteristic symptoms lasting from three days to one month following exposure to one or more traumatic events” (American Psychiatric Association, 2013, p. 281).

**Compassion Fatigue-** The emotions and behaviors that result from knowing about a traumatic event experienced by another person (Figley, 1995).

**Crisis-** “A state of emotional turmoil wherein one’s usual coping mechanisms have failed in the face of a perceived challenge or threat (Mitchell & Everly, 2000, p. 72).

**Critical Incident-** “An event which is outside the usual range of experience and challenges one’s ability to cope” (Everly & Mitchell, 2000, p. 212).

**Crisis Intervention-** “The natural operational corollary of the conceptualization of the term crisis” (Everly & Mitchell, 2000, p. 212).

**Emergency Medical Responder-**

The primary focus of the emergency medical responder is to initiate immediate lifesaving care to critical patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response and to assist higher level personnel at the scene and during transport. Emergency medical responders function as part of a comprehensive EMS response, under medical oversight. Emergency medical responders perform basic interventions with minimal equipment (NREMT.com).

**Emergency Medical Technician-**

The primary focus of the emergency medical technician is to provide basic emergency medical care and transportation for critical and emergent patients who access the emergency medical system. This individual possesses the basic knowledge and skills necessary to provide patient care and transportation. Emergency medical technicians function as part of a comprehensive EMS response, under medical oversight. Emergency medical technicians perform interventions with the basic equipment typically found on an ambulance. The emergency medical technician is a link from the scene to the emergency health care system (NREMT.com).

**External Debriefing-** External professional resources providing support services (Halpern, et al., 2008).

**Loved Ones-** Loved ones are defined as individuals who are family, friends, or individuals who had significant relationships to the deceased.

**First Responder-** Encompasses emergency and paramedical teams, police officers, fire response, search and rescue personnel, “those individuals in the early stages of an accident or

disaster, are responsible for the protection and preservation of life, property, and the environment” (Prati & Pietrantonio, 2010, p. 403).

**Internal Debriefing-** Crisis intervention services provided by members of the same organization (Revicki & Gershan, 1996).

**Multifaceted Traumatization-** The combination of EMS personnel’s direct exposure to a completed suicide and the vicarious exposure where loved ones of the deceased were present.

**Paramedic-**

The Paramedic is an allied health professional whose primary focus is to provide advanced emergency medical care for critical and emergent patients who access the emergency medical system. This individual possesses the complex knowledge and skills necessary to provide patient care and transportation. Paramedics function as part of a comprehensive EMS response, under medical oversight. Paramedics perform interventions with the basic and advanced equipment typically found on an ambulance.

The Paramedic is a link from the scene into the health care system (NREMT.com)

**Phenomenon-** “A philosophy or theory of the unique, it is interested in what is essentially not replaceable” (van Manen, 1990, p. 7).

**Positive Psychology-** “The scientific study of what makes life most worth living” (Lopez & Snyder, 2009, p. xxii).

**Post Traumatic Stress Disorder (PTSD)-** According to the American Psychiatric Association (2013), a diagnosis of PTSD may be given when a person has been exposed to a traumatic event and thus experiences negative psychological symptoms. An individual must have experienced, witnessed, or have been confronted with a traumatic event(s) that involved a serious threat to self

or others and must have involved intense fear, horror, and feelings of helplessness (American Psychiatric Association, 2013).

**Trauma-** The American Psychological Association (2013) defines trauma under the diagnosis of PTSD as:

Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains; police officers repeatedly exposed to details of child abuse) (American Psychiatric Association, 2013, p. 280).

**Vicarious Traumatization-** A trauma worker's "inner experience" of providing empathy to a trauma-exposed individual (Pearlman & Saakvitne, 1995).

### **Overview of the Dissertation**

In chapter one of the dissertation study I provided an overview of the study. I have included information on each concept that is to be studied. I have also included the research design, significance of the study, and data collection. Chapter two of the dissertation provides a review of the literature on the phenomena being studied including traumatization, suicide, and family and loved ones presence during medical interventions. Included is a history of the involvement of stress-related disorders in the diagnostic and statistical manual of mental disorders and a review of traumatic exposure literature. Specially, the traumatic exposure of emergency

medical responders is reviewed which focuses on the effects of trauma and the development of crisis intervention mechanisms which aide in a return to normal functioning. The literature on suicide is also reviewed which includes statistical and demographical information, suicide methods, risk factors, and suicide survivors. Lastly, the research on the presence of family and loves ones during emergency medical interventions is reviewed.

Chapter three reviews the methodology, purpose, and research design of the study. In addition, the sample, participant selection, data collection, interview questions, method, and instrumentation are reviewed. I have also included ethical considerations, limitations, and delimitations. Finally, a chapter summary completes this chapter. Chapter four provides the results of the data collected from participants. Chapter five provides the data explication and the limitations of the study, implications for the field of emergency medical services, and suggestions for future research. Finally, the appendices include the recruitment letter, the recruitment flyer, the informed consent document, and the demographic survey.

## **Chapter II: REVIEW OF THE LITERATURE**

### **Introduction**

A review of the literature is necessary to explore the phenomenon being studied and to identify gaps that have heretofore been under explored. Chapter two provides a review of the research that has been conducted on emergency medical services, exposure to traumatic events, crisis intervention, suicide, and presence of family and loved ones during medical interventions. The review of the literature includes emergency medical responder distress, personal and work-related stress, mental health implications, crisis intervention responses, self-care techniques, and response to mental disturbance calls. I identify the gaps in the literature related to the phenomenon of direct and vicarious exposure to traumatic events and presence of family and loved ones during such events. This review demonstrates the need for an in-depth, qualitative study on EMS personnel responding to completed suicides where loved ones of the deceased were present.

### **History of Trauma**

Trauma has been examined for many centuries and continues to be an area of interest among researchers (Figley, 1985; Turnbull, 1998). The phenomenon of the effects of trauma, now known as stress-related disorders, appeared in readings from centuries ago, such as Shakespeare in Henry IV and Homer in his Iliad. The survivors of the Great Fire of London in 1666 also described these post stress reactions, such as Samuel Pepys, diarist, who stated: “A horrid, malicious blood fire...so great was our fear, it was enough to put us out of our wits” (Figley, 1985; Turnbull, 1998, p. 87). Charles Dickens described symptoms of PTSD after surviving a traumatic train crash in Staplehurst, Kent in the late 1800’s where he also served as a rescue worker to the victims, “...two or three hours work amongst the dead and dying

surrounded by terrific sights...I am not quite right within...but believe it to be an effect of the railway shaking” (as cited in Figley, 1985, p. 7).

In the 17<sup>th</sup> century, European physicians became cognizant of the “illness” that soldiers experienced following combat, which resulted in significant negative emotional reactions (Babington, 1997). Initially, returning soldiers were diagnosed with ‘exhaustion’ following battle stress (Ray, 2008) and symptoms began to be defined as “shell shock” or “combat fatigue” (Andreasen, 2004; Ray, 2008). World War II was the event that prompted thorough examination and research on the psychological symptoms returning soldiers experienced, and therefore a formal diagnosis, ‘gross stress reaction,’ was developed based upon these criteria in the first DSM (Andreasen, 2004). The DSM has evolved since its first edition to include formal diagnoses following traumatic exposure and has provided a common language and standard criteria for the classification of mental disorders. The following paragraphs are a review of stress-related disorders in all revisions of the DSM. It is important to review stress-related disorders in order to gain an understanding of how these disorders have evolved and how individuals can be affected by traumatic exposure.

### **Diagnostic and Statistical Manual of Mental Disorders (DSM)**

The American Psychiatric Association (APA) developed the first DSM in 1952 to provide professionals with a common language and standard criterion for the diagnosis of mental disorders (Briere & Scott, 2013). The DSM-I has been revised multiple times from its original edition in 1952 to its most recent edition, DSM-V that was published in 2013. There is an ample amount of evidence to support that traumatic exposure can lead to psychological symptoms which meet diagnostic criteria within the DSM (Hyatt-Burkhart & Levers, 2012). Therefore, the following is a review of the stress-related disorders in all revisions of the DSM.



**DSM-I.** Mental health professionals began to examine the psychological symptoms soldiers experienced following combat, as well as additional traumatic events that the general population experienced such as fires, plane crashes, and natural disasters. The first acknowledgement of a stress-related disorder was considered at this time and a formal diagnosis for these symptoms was developed in the first edition of the DSM: “gross stress reaction” (GSR) (APA, 1952). The diagnosis of GSR required that the individual had been exposed to severe emotional stress or extreme physical demands such as from combat or other catastrophes (Spitzer, First, & Wakefield, 2007).

**DSM-II.** Initially, those individuals modifying the second edition of the DSM were advocating for a “post-Vietnam syndrome” diagnosis for soldiers who experienced psychological symptoms following combat, but were unsuccessful in developing this diagnosis (Andreasen, 2004). Despite the diagnosis of GSR in the DSM-I, it was dropped from the DSM-II (Andreasen, 2004). Rather, Turnbull (1998) states the DSM-II added “adjustment reaction of adult life” to diagnose stress-related symptoms, but failed to include many traumatic events (e.g. sexual trauma, car accidents) (APA, 1968).

**DSM-III.** The first diagnostic classification of “posttraumatic stress disorder” was developed in the third edition of the DSM, which was published in 1980 (Turnbull, 1998). Van der Kolk & McFarlane (1996) describes the recognition of PTSD as a “validation” for individuals experiencing psychological distress, and has provided an opportunity for increased studies of human suffering. The criteria for this diagnosis was developed based upon the existing literature from the psychological symptoms soldiers experienced coming home from the Vietnam War, as well as symptoms experienced by Holocaust survivors (Turnbull, 1998). A 27-item questionnaire was developed in 1975 and administered to over 700 Vietnam veterans. The results

of this study assisted in the diagnosis of PTSD (Turnbull, 1998). Prior to the publication of the DSM-III in 1980, research had begun to be conducted on other traumatized populations including victims of accidents, sexual abuse victims, children abuse, etc., which also contributed to the formal diagnosis of PTSD in the DSM-III (Turnbull, 1998). Two types of diagnostic criteria of PTSD were included; acute and delayed types (Andreasen, 2004). The primary criterion for PTSD was that an individual must have experienced a life-threatening event that would result in symptoms of distress in everyone (Zoellner, Bedard-Gilligan, Jun, Marks, & Garcia, 2013). The following criteria must be met for PTSD in the DSM-III:

(A) Existence of a recognizable stressor that would evoke significant symptoms in almost everyone.

(B) Re-experiencing of the trauma as evidenced by at least one in the following:

(1) Recurrent and intrusive recollections of the event.

(2) Recurrent dreams of the event.

(3) Sudden acting or feeling as if the traumatic event were recurring, because of an association with an environmental or ideational stimulus.

(C) Numbing of responsiveness to, or reduced involvement with, the external world, beginning some time after the trauma, as shown by at least one of the following:

(1) Markedly diminished interest in one or more significant activities.

(2) Feeling of detachment or estrangement from others.

(3) Constricted affect.

(D) At least two of the following symptoms that were not present before the trauma:

(1) Hyperalertness or exaggerated startle response.

(2) Sleep disturbance.

- (3) Guilt about surviving while others have not, or about behavior required for survival.
- (4) Memory impairment or trouble concentrating.
- (5) Avoidance of activities that arouse recollection of the traumatic event.
- (6) Intensification of symptoms by exposure to events that symbolize or resemble the traumatic event (APA, 1980).

**DSM-III-R.** The criterion for PTSD was modified in the revised version of the DSM-III. The DSM-III-R (revised) incorporated new research findings and there was emphasis on avoidance phenomena (Turnbull, 1998). A conceptual definition of trauma was provided, which was described as an event outside of one's normal human experience that would be distressing for anyone (Spitzer, et al., 2007). The addition of criterion E was included to incorporate duration of the disturbance of at least one month (APA, 1987). The requirement that the stressor be outside the normal range of human experience was removed from the DSM-III-R and acute type of PTSD was also removed (Andreasen, 2004).

**DSM-IV.** Acute PTSD, which was removed from the DSM-III-R, was added under a separate diagnosis, "acute stress disorder" (ASD) in the DSM-IV (Andreasen, 2004). For symptoms experienced immediately following exposure to the traumatic event, ASD is given, as opposed to PTSD criteria of at least 30 days since the traumatic exposure (Briere & Scott, 2013). Andreasen (2004) identifies the addition of criterion F to the diagnosis of PTSD to include significant psychological distress or impairment in functioning from the disturbance (APA, 1994). Andreasen (2004) also identifies additional modifications: the definition of "stressor" was identified to describe events that may result in serious injury or death, or physical harm to self or with others (criterion A1) and as an event that evoked an emotional response of intense fear,

helplessness, or horror (criterion A2) (APA, 1994). If an individual does not meet criteria for PTSD or ASD, the DSM-IV developed the diagnosis of an “adjustment disorder,” which captures symptoms of depression, anxiety, and disturbances following a stressful event (Briere & Scott, 2013).

**DSM-IV-TR.** Some minor changes were made for criterion of PTSD from the DSM-IV to the DSM-IV-TR. One change included the PTSD criteria in the DSM-IV, which stated the traumatic experience must be outside of the “normal” human experience, while the DSM-IV-TR included experiences that may be in the “normal” human experiences, such as traffic accidents (APA, 2000). Another revision to the diagnosis of PTSD, was the addition of “re-experiencing” episodes of the traumatic events (e.g. dreams, intrusive thoughts, acting as if the event was re-occurring) (APA, 2000). In the modified DSM-IV-TR, there was significant emphasis on the emotional reaction to the event, such as increased anger outbursts or difficulty sleeping (APA, 2000).

**DSM-V.** DSM-V modifications to PTSD include:

The main criteria changes for DSM-5, compared with DSM-IV, 5 include the removal of Criterion A2 (subjective response to the traumatic event), the separating of active avoidance from passive avoidance (Criterion C), and the creation of a new cluster of symptoms (Criterion D - negative alterations in cognitions and mood). The hyperarousal cluster (Criterion D in DSM-IV) generally remains the same but is now Criterion E... Re-experiencing symptoms are contained to those research findings unique to PTSD, namely flashback and nightmares (O’Donnell, et al., 2014, p. 230).

In addition to PTSD, ASD, and adjustment disorder, the DSM has included additional diagnoses that may be provided for individuals suffering from the effects of traumatic exposure.

The DSM-V includes the following diagnoses: generalized anxiety disorder, panic disorder, other specified trauma-and-stressor related disorder, and unspecified trauma-and-stressor-related disorder (APA, 2013). The following paragraphs describe the criteria for these diagnoses.

“Generalized anxiety disorder” may be diagnosed following traumatic exposure and the criterion includes “excessive anxiety and worry (apprehensive expectation about a number of events or activities)” (APA, 2013, p. 222). “The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event” (APA, 2013, p. 209). A panic attack, as a criterion for panic disorder, is described as “the abrupt surge of intense fear or intense discomfort that reaches a peak within minutes, and during which time four or more of a list of 13 physical and cognitive symptoms occur” (APA, 2013, p. 209).

The diagnosis of “other specified trauma and stressor-related disorder” is diagnosed when symptoms do not meet the criteria for another stress-related disorder, but cause “significant distress or impairment in social, occupational, or other important areas of functioning” and when the clinician chooses to identify the reason why it does not meet the criteria (APA, 2013, p. 289). The diagnosis of “unspecified trauma and stressor-related disorder” is used when the clinician chooses not to identify the reason why it does not meet the criteria.

The DSM-V identifies “other specified anxiety disorder” when full criteria is not met for another anxiety disorder, and when the clinician chooses to identify the reason that it does not meet the criteria for another anxiety disorder (APA, 2013). The “unspecified anxiety disorder” is also given when criteria are not met for another anxiety disorder, but the clinician chooses not to identify why it does not meet the criteria for other anxiety disorders (APA, 2013). A diagnosis of “anxiety disorder not otherwise specified” (NOS) may also be applied if an individual does not meet all criteria for other stress-related disorders (APA, 2013).

Symptoms of depression may also be resulted following exposure to trauma (Briere & Scott, 2013). Individuals with a history of trauma can present with symptoms of depression, including feelings of worthlessness, extreme sadness, hopelessness, loss of interest, sleep disturbance, lack of energy, and suicidality (Briere & Scott, 2013). Many studies in the literature indicate that those with trauma history are at risk to progressing to major depressive disorder (Breslau et al., 1991; Kessler et al., 1995).

In addition to anxiety and depressive disorders, other mental health disorders can be diagnosed among individuals with a history of trauma, as well as comorbid physiological health related complications (Briere & Scott, 2013; Zayfert, Dums, Gerguson, & Hegel, 2003; Schnurr & Green 2004). Some mental health disorders may include alcohol and substance related disorders, dissociative disorders, somatization disorders, conversion disorders, psychotic disorders, and borderline personality disorder (Briere & Scott, 2013). There is an increased risk of health issues with individuals with mental health disorders (Zayfert, et al., 2003; Schnurr & Green 2004). Individuals diagnosed with PTSD are at risk for the following physiological health issues: hypertension, nervous system disease, arthritis, back pain, cancer, digestive disorders, chronic pain, back pain, stroke, and endocrine disorders (Dobie, et al., 2004; Frayne, et al., 2004; Phifer, et al., 2011; Spitzer, et al., 2009).

In the daily duties of emergency medical responders and other first responder personnel, exposure to traumatic events is common. Individuals working in these helping professional fields have a greater chance of developing stress related symptoms and disorders, such as those identified in the above paragraphs. The following is a review of the literature on the effects of repeated traumatic exposure in helping professional fields.

## **Emergency Medical Responder Distress and Effects**

Some professionals, such as emergency medical services personnel, are directly exposed to trauma scenes in their daily duties. The following paragraphs provide a review of the effects in which EMS workers experience from their daily duties as an emergency medical provider. It is important to understand these effects to identify what mechanisms have been developed and what mechanisms need to be developed to improve coping abilities for EMS personnel.

The emergency medical services profession consists of a variety of types of first responders including police officers, emergency room personnel, firemen, paramedics, emergency medical technicians (EMTs), and crisis mental health workers. The role of first responders is to provide emergency services and/or pre-hospital care to patients experiencing physical and mental health issues (Elmqvist, Brunt, Fridlund, & Ekebergh, 2009; Prati & Pietrantonio, 2010). During their duties, first responders are directly exposed to traumatic events where their ability to respond effectively in high-risk situations is critical (Prati & Pietrantonio, 2010). Due to the repeated exposure to traumatic events, negative psychological and physiological effects may be experienced by some first responders (Williams, et al., 2008).

Much of the research conducted on the psychological effects among EMS following traumatic events has focused on two areas: the continuous exposure to trauma such as repeated exposure of a combination of car accidents, natural disasters, death, death/injury to a child, death/injury to a partner, and suicide (Regehr, et al., 2002; Regehr, Hill, Goldberg, & Hughes, 2003) or events that have gained significant public attention, such as the September 11<sup>th</sup> attacks. However, there is research that suggests that paramedics who provide even “routine” care, such as performing CPR (Beaton, et al., 1998) or arriving to the scene of the death of an elderly

person or a completed suicide (Regehr, et al., 2002) can result in the development of symptoms of PTSD.

Trauma exposure can affect various aspects of an individual's life, including personal relationships and one's emotional stability. Emergency medical responders returning home after a day of repeated traumatic scenes in their duties may experience personal challenges. Regehr (2005) indicated challenges within family relationships, such as lack of involvement with families, in which children may feel isolated or abandoned by the first responder parent. Family members and loved ones of trauma-exposed individuals may also experience posttraumatic symptoms, similar to those who have directly experienced the trauma themselves (Duarte, et al., 2006; Hoven, et al., 2009; McCann & Pearlman, 1990). Mental health issues may be experienced by some individuals who are exposed to traumatic events. Symptoms may include depression (Regehr, et al., 2002), sleep disturbances (Fullerton, et al., 1992; Ussery & Waters, 2006), substance abuse (Ussery & Waters, 2006), and PTSD (Clohessy, Ehlers, & Anke, 1999; Perrin, et al., 2007; Regehr, et al., 2002).

## **PTSD**

The rate of developing PTSD as emergency medical services providers has been reported as higher than the general population (Carlier, et al., 2000; Clohessy, Ehlers, & Anke, 1999; Perrin, et al., 2007; Regehr, et al., 2002). As briefly mentioned in chapter one, in Clohessy and Ehlers's (1999) study, the rate of developing PTSD as an ambulance worker was 21% among participants, in comparison to the rate of 4% in the general population (Kleim & Westphal, 2011). Regehr, et al. (2002) conducted a study on the effects of traumatic exposure on paramedics and concluded that over 25% of the respondents in the study fell into the high or severe range of PTSD symptoms, 14% fell into the moderate range, and 44% fell into the low



range of symptoms. Van Der Ploeg and Kleber (2003) concluded that 12% of ambulance workers met criteria for “severe” symptoms of posttraumatic stress following one or more traumatic events. A study on EMS following hurricane Katrina indicated that all participants reported having symptoms of PTSD (Tracey, 2007). Other studies conducted by Carlier, et al., (2000) and Jonsson, Segesten, and Mattsson (2003), found similar findings indicating higher rates of PTSD among first responders than the general population. Jonsson, et al. (2003) stated “...it can be assumed that ambulance workers with many years in the service have a long history of many stressful events” (p. 83), ultimately leading to higher rates of PTSD.

In addition to a diagnosis of PTSD, approximately 80 percent of individuals with PTSD also have a comorbid mental health diagnosis, which can include depressive disorders, anxiety disorders, personality disorders, psychotic disorders, and substance related disorders (Briere & Scott, 2013). Therefore, it can be assumed that emergency medical responders presenting with significant symptoms of acute stress, PTSD, or other stress related disorders, may also be presenting with comorbid mental health diagnosis as Briere and Scott (2013) suggest. The cost of being a member in the helping profession can significantly result in a variety of potential effects. The following paragraphs provide a review of the risks of fatigue and burnout in being a member in a helping profession.

### **The Cost of the Helping Profession**

The study of traumatic exposure has provided a better understanding of the effects of the helping profession (Gentry, 2002). The impact from being a ‘helper’ has emerged in the trauma literature and continues to be an interest among researchers (Figley, 1995; Maslach & Jackson, 1981; Maslach, et al., 2002; McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995). The literature “attempts to identify and define the traumatization of helpers through their efforts of

helping” (Gentry, 2002). Many terms have been identified to describe this phenomenon including “burnout” (Maslach & Jackson, 1981; Maslach, et al., 2002), “compassion fatigue” (Figley, 1995) and “vicarious traumatization” (McCann & Pearlman, 1990; Pearlman & Saakvitne, 1995).

## **Burnout**

The phenomenon of burnout began to be discussed in the 1970’s among people working in the helping profession (Figley, 1995; Maslach & Jackson, 1981). Its roots were in service and care-giving professions in which the significant role was between professional and recipient, and the studies were conducted to explore the professional relationships in the job (Maslach, et al., 2002). Burnout is now studied among various professional roles that extend far beyond helping professionals (e.g. military, management, clerical work, and technology) (Maslach, et al., 2002).

Maslach (2003) defines burnout as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work” (p. 2). Maslach and Jackson (1981) describe the symptoms of burnout as “emotional exhaustion and cynicism” in helping professions. Helping professional personnel who experience burnout are often left feeling inadequate in their ability to engage in empathy with their clients (exhaustion), experience feelings of cynicism toward their clientele, and often question their professional effectiveness (Maslach & Jackson, 1981; Maslach, et al., 2002).

While experiencing symptoms of burnout, professionals may question their abilities to help their clients and feel dissatisfied with their success at work (Farber & Heifetz, 1982; Maslach & Jackson, 1981). Emotional and physical health issues such as family and marital issues, drug and alcohol use, personal distress, and physical exhaustion, may be associated with burnout (Maslach & Jackson, 1981).

Assessments and inventories have been developed to measure burnout symptoms of helping personnel. The Maslach Burnout Inventory (MBI) is the most common and widely used inventory among researchers (Figley, 1995; Maslach & Jackson, 1981). The first edition of the MBI, MBI-Human Services Survey, was initially developed to assess burnout among helping professionals (Maslach, et al., 2002). A second version, MBI-Educators Survey, or MBI-ES, was developed to measure burnout among educational personnel (Maslach, et al., 2002). Finally, a third version, MBI-General Survey, or MBI-GS, was developed to measure burnout in positions that are not necessarily people oriented (Maslach, et al., 2002). All three versions measure the three components of burnout: emotional exhaustion, cynicism, and decreased professional effectiveness (Maslach, et al., 2002).

The three components of burnout have been analyzed by researchers over the years. The first component, exhaustion, is the most common symptom described by professionals experiencing symptoms of burnout (Maslach, et al., 2002). Exhaustion may follow with the creation of distance between one's self and one's work, in order to cope with the overwhelming stressors at the job (Maslach, et al., 2002). The second component, decreased personal effectiveness or accomplishment, appears more complex (Maslach, et al., 2002). A job position with overwhelming stressors can create a feeling of decreased sense of accomplishment (Maslach, et al., 2002). Lastly, cynicism describes the distance from one's own work, rather than a physical distance from people (Salanova, et al., 2005).

Researchers have looked at the characteristics of individuals who are more likely to experience symptoms of burnout, including demographic characteristics, personality traits, and job attitudes (Maslach, et al., 2002). Demographic characteristics (age, sex, race, education, occupation) have been researched, but only few correlations have been found between

demographics and rates of burnout (Maslach, et al., 2002). Multiple studies have concluded that younger employees (under 30) are more likely to have higher rates of burnout than other ages (Craig & Sprang, 2010; Maslach, et al., 2002). Those with higher scores of cynicism (males), higher scores of exhaustion among females, unmarried marital statuses (especially men), and higher levels of education, have increased burnout symptoms (Maslach, et al., 2002). Personality traits, such as: people who have an external, rather than internal locus of control, passive/defensive coping methods, and lower self-esteem all contribute to higher rates of burnout (Maslach, et al., 2002). Lastly, those individuals with high expectations in their jobs are also more likely to experience symptoms of burnout (Maslach, et al., 2002).

Symptoms of burnout can be managed and improved from both an individual and organizational perspective (Maslach, et al., 2002). From an individual perspective, interventions such as relaxation techniques, assertiveness training, time management, mediation, and social skills training, can be implemented to decrease symptoms of exhaustion (Maslach, et al., 2002). In addition, individuals are encouraged to have activities and interests outside of work as an escape from overwhelming stress (Farber & Heifetz, 1982). From an organizational perspective, changes in management and educational interventions may be implemented to reduce burnout symptoms (Maslach, et al., 2002). There may be an improved tolerance of workload if individuals are being well-rewarded (Maslach, et al., 2002).

### **Compassion Fatigue**

In addition to burnout, compassion fatigue (CF) is described as the emotional response from knowledge of a traumatic event (Figley, 1995). Figley (1995) describes this reaction as a natural response developed from the desire to want to help traumatized individuals. Figley (1995) began studying this phenomenon in the early to mid 1980's, in which he initially

described as ‘burnout’ or ‘secondary victimization’ and has since referred to as compassion fatigue (CF). This reaction is the consequence to being in a helping profession, “The picture that emerges is clear: Those who work with the suffering suffer themselves because of the work” (Figley, 2002a, p. 5).

Individuals in a helping professional role may experience this phenomenon, which Figley (1995) describes as CF. Individuals “who have enormous capacity for feeling and expressing empathy” are more likely to develop compassion stress (Figley, 1995, p. 1; Gentry, 2002). CF is different than burnout, in that it results from one’s emotional response from client’s descriptions of traumatic events, rather than work-related stress (Figley, 1995). Figley (1995) spent about a decade talking to many professionals about the phenomenon of indirect exposure to trauma. Figley (1995) describes risk among therapists from experiencing similar feelings of pain and suffering because of the empathetic nature and caring they do in their daily jobs (Figley, 1995). Therapists are often told horrific stories described by clients who have experienced significant traumatic events. For example, a therapist working with an individual with a history of sexual abuse may develop disgust toward perpetrators and potentially all males (Figley, 1995). Figley (1995) describes compassion fatigue as “equivalent” to symptoms of PTSD, whereas PTSD is associated with individuals with direct exposure to trauma, while compassion fatigue or secondary victimization is associated with individuals with indirect exposure to trauma (Figley, 1995; Figley 2002a).

Multiple instruments have been developed and evolved to measure compassion fatigue. Figley (1995) developed the first measurement of compassion fatigue, Compassion Fatigue Self Test, where multiple versions were created and used to assess compassion fatigue/secondary victimization (Stamm, 2005). The current version is The Professional Quality of Life Scale

(ProQOL), which is used across various professions and contains three subscales: Compassion Satisfaction, Burnout, and Compassion Fatigue (Stamm, 2005).

Treatment of CF has been reviewed by multiple researchers and can be implemented using the following implications (Figley, 2002b; Gentry, 2002). First, educate oneself with an overview of CF through professional journals, the web, and the library. Second, increase desensitization to traumatic stressors through increased exposure. Third, increase engagement in relaxation and engagement in recreational activities. Lastly, the fourth implication is to increase social support systems (Gentry, 2002). Gentry (2002) further describe techniques one can do to reduce symptoms of compassion fatigue: self-soothing, such as meditation and exercise; increased education on trauma therapy, such as EMDR; and implementing positive self-talk and use of self-accepting language. Lastly, therapists are encouraged to talk about personal struggles with CF and are encouraged to use professional services to desensitize from traumatic stressors (Figley, 2002b).

### **Vicarious Traumatization**

In addition to ‘burnout’ (Maslach & Jackson, 1981; Maslach, et al., 2002) and ‘compassion satisfaction’ (Figley, 1995), Pearlman & Saakvitne (1995) coined the term, ‘vicarious traumatization,’ to describe the trauma worker’s “inner experience” of providing empathy to a trauma-exposed individual. Providing this empathetic engagement can result in increased vulnerability among the trauma worker and can result in similar effects of direct trauma exposure (Pearlman & Saakvitne, 1995). This may include witnessing or engaging in reenactments of the traumatic event and listening to detailed descriptions of horrendous events and individuals vicious actions (Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). This experience may affect one’s identity, sense of meaning, interpersonal relationships, beliefs about

one's self and others, and world-view (McCann & Pearlman, 1990; Pearlman & Mac Ian, 1995; Pearlman & Saakvitne, 1995). McCann & Pearlman (1990) also describe the disruption in schemas about the self and the world when working with trauma-exposed individuals.

Similar to individuals directly exposed to trauma, trauma workers experiencing this vicarious traumatization can experience psychological and physical symptoms such as depression, distance from friends and family, and difficulty performing work roles (Pearlman & Saakvitne, 1995). These effects may or may not be experienced by trauma workers and may depend on the worker's personal characteristics and personal and professional experiences (Pearlman & Mac Ian, 1995). Personal characteristics and experiences may include current life stressors, support systems, personal history of traumatic exposure, and one's *meaning* of trauma (Pearlman & Mac Ian, 1995). Professional experiences can include the context presented, the work environment, and social and cultural factors (Pearlman & Mac Ian, 1990).

A study conducted by Pearlman and Mac Ian (1995) indicated findings similar across vicarious traumatization literature. They found that for the most part, trauma therapists tend to function pretty well overall (Pearlman & Mac Ian, 1995). However, Pearlman and Mac Ian (1995) found that trauma therapists with a personal trauma history are more likely to experience disruptions than those without personal trauma history. Similar to other research findings (Deutsch, 1984), Pearlman and Mac Ian (1995) concluded that trauma therapists with minimal professional experience are more likely to suffer from vicarious traumatization, such as experiencing significant stress-related symptoms. Trauma therapists may leave the field early if they have difficulty coping with work related stress. Therapists who have years of experience and gain trauma knowledge, may be more likely to cope effectively (Deutsch, 1984; Pearlman & Mac Ian, 1995). Over time, therapists are likely to have engaged in consultation, supervision, and

continuing education services that have helped to maintain boundaries between themselves and their clientele (Pearlman & Mac Ian, 1995).

### **The Cost of the Helping Profession on Loved Ones**

In addition to the psychological and physical affects that trauma workers experience, loved ones of traumatized individuals can also be affected through vicarious traumatization (Duarte, et al., 2006; Hoven, et al., 2009; McCann & Pearlman, 1990). Research suggests that stress-related disorders, such as PTSD, are greater with emergency medical responders, but one must consider the effects that traumatization has on their loved ones. Family members or loved ones, including children, of the trauma-exposed individual may also experience negative effects similar to that of the traumatized individual (McCann & Pearlman, 1990). A predictor of a child's mental health stability following family member experiences of a traumatic event is the psychological functioning of the parent (Laor, Wolmer, & Cohen, 2001). Studies have suggested that children are at a higher rate of experiencing significant mental suffering (Hoven, et al., 2009) and development of stress related symptoms, such as PTSD when their parents have symptoms of PTSD (Duarte, et al., 2006). In a study conducted by Hoven, et al. (2009), "There is preliminary evidence suggesting that these children have experienced significant mental suffering related to their parents' exposure..." (p. 108). Researchers conducted a study on first responders family members following the September 11<sup>th</sup> attacks and suggested children's symptoms of PTSD were developed through secondary/vicarious traumatization (Duarte, et al., 2006). The results of this study indicated a higher rate of PTSD symptoms in children with emergency response family members who responded to the 9/11 attacks than other children (Duarte, et al., 2006). These studies support increased likeliness of post trauma symptoms among first responder loved ones and children.



The research supports that individuals who have experienced a traumatic event are more likely to recover and return to normal functioning rather than developing a significant mental health concern. In addition, some individuals may even experience positive outcomes following traumatic exposure. Despite the emphasis on negative consequences following traumatic exposure, a more recent trend in the literature has focused on the positive effects that some experience. The positive response following traumatic exposure, known as posttraumatic growth, has been a new area of interest among the trauma literature. The following is a review of positive psychology and the growth that has resulted from traumatic exposure.

### **Positive Psychology**

Positive psychology was first discussed by Abraham Maslow in 1954 when he shifted the negative connotation of psychology, into a more positive and optimistic approach (Lopez & Snyder, 2009). Later, Martin Seligman termed ‘positive psychology’ as “the scientific study of what makes life most worth living” (Lopez & Snyder, 2009, p. xxii; Seligman, 2002). “Positive psychology revisits the “average person” with an interest in finding out what works, what is right, and what is improving” (Sheldon & King, 2001, p. 216). Psychology does not always have to be viewed as a disease or a form of damage, rather can be viewed as a study of optimism and strength (Seligman, 2002). Researchers began to explore the concept of positive psychology by exploring the interventions and tools that had helped to explain the focus on “negative” psychology (Lopez & Snyder, 2009).

### **Posttraumatic growth**

Despite the amount of literature on the negative effects from traumatic exposure, there has been a recent focus on healthy functioning among individuals who have been exposed to traumatic events (Bonanno, 2004). Various names have been given to describe this healthy

functioning: perceived benefit (Affleck & Tennen, 1996), stress-related growth (Park, et al., 1996), thriving (O’Leary, 1998), and posttraumatic growth (Tedeschi & Calhoun, 1995). Tedeschi, Park, and Calhoun (1998) conducted research on the individuals who identified resiliency from traumatic exposure, but also used their traumatic exposure experiences for personal growth. For some, the traumatic event provides a new opportunity for building a new, *superior*, lifestyle (Tedeschi, et al., 1998), “...An exclusive focus on negative outcomes has precluded exploration of the possibility that, over time, people “grow” from these negative events” (Park, et al., 1996).

Posttraumatic growth (PTG) is defined as the positive psychological change after experiencing a traumatic event or a major life crisis (Tedeschi & Calhoun, 1994; 1995; Tedeschi, Calhoun, & Cann, 2007). Despite the attention given toward negative experiences following traumatic events, most people are able to cope well following traumatic events (Brady et al., 1999). Tedeschi & Calhoun (1994) have concluded that far more people experience growth from traumatic exposure than those who meet criteria for a psychiatric diagnosis. One article that looked at psychiatric diagnosis following traumatic exposure, suggested that about 4% of the general population meet criteria for PTSD (Kleim & Westphal, 2011), indicating that about 96% of people return to normal functioning, and some people even report having positive outcomes from the traumatic event (Steed & Downing, 1998). PTG signifies personal strength, a sense of spirituality, an improved appreciating and satisfaction of life, relational intimacy, and an awareness of life possibilities (Dekel, Ein-Dor, & Solomon, 2012).

More recently, the concept of emergency medical responder resiliency and posttraumatic growth has been explored (Pietrantonio & Prati, 2008; Shakespeare-Finch, Smith, Embelton, & Baird, 2003). In a study conducted by Shakespeare-Finch, et al. (2003), a majority (98.6%) of

first responder participants reported having a positive change following a traumatic work event. Positive changes were identified in four ways: increased personal strength, increased appreciation for life and relationships, religious and spiritual changes, and finding new possibilities (Shakespeare-Finch, et al., 2003).

To increase the healthy functioning among trauma-exposed individuals, interventions have been identified to increase stabilization and assist individuals in returning to normal functioning. Crisis intervention techniques were developed for members of helping professions many years ago and continue to be utilized in various settings. The following is a review of the literature on crisis intervention techniques and interventions.

### **Crisis Intervention**

Many crisis intervention mechanisms have been identified, researched, and used among members of helping professions to increase coping abilities with traumatic events. An overview of the research appears to be conflicting, as some research supports crisis interventions, while other research concludes negative or even harmful results. The following is a review of crisis interventions among the helping fields.

#### **Definition of Crisis**

Various definitions have been used to describe the definition of ‘crisis.’ Mitchell and Everly (2000, p. 72) define ‘crisis’ as “a state of emotional turmoil wherein one’s usual coping mechanisms have failed in the face of a perceived challenge or threat (Mitchell & Everly, 2000, p. 72). Crisis is also described as “a response to some aversive situation, manifest, or anticipated, wherein:

- 1) psychological homeostasis (equilibrium) is disrupted;
- 2) one’s usual coping mechanisms have failed to reestablish homeostasis; and

3) there is evidence of functional distress or impairment” (Caplan, 1961; Everly & Mitchell, 1999, p. 212).

### **Social Support**

All individuals require some support mechanisms in their lives and we know that any crisis response approach introduces social support systems (Mitchell & Everly, 2000). Research conducted on emergency medical responders’ exposure to traumatic events indicates that social support is an effective coping mechanism utilized by many first responders after traumatic events (Regehr, et al., 2003). Support from family members, friends, and professionals have shown to significantly decrease posttraumatic symptoms following traumatic events (Briere & Scott, 2013). Professional support services, known as crisis intervention, began to evolve in the 1960’s and 1970’s with various support services, such as telephone hotlines and walk-in crisis services (Mitchell & Everly, 2000). Crisis intervention was designed to increase stabilization, mitigate distress or impairment, restore to normal functioning, and engage in increased levels of care if necessary (Everly & Mitchell, 1999; 2000).

### **Critical Incident Stress Management**

In order to provide adequate care to members of the helping professions, critical incident stress management (CISM) was evolved from the works of Eric Lindemann, Gerald Caplan, Howard Parad, and Irvin Yalom, who helped develop crisis intervention theories and practices of the last century (Mitchell & Everly, 1986). CISM is described as “a comprehensive, integrated, systematic and multi-component crisis intervention program” (Mitchell & Everly, 1986, p. 1). CISM is *comprehensive* in that it provides crises management education and interventions for use during and following traumatic events (Mitchell & Everly, 1986). It is *integrated* in that the elements of CISM are merged into a cohesive method during crisis intervention (Mitchell &

Everly, 1986). CISM is *systematic*, meaning elements of the program are provided in a step-by-step process (e.g. crisis interventions start with individual sessions, then group sessions, then a referral to additional support or treatment services) (Mitchell & Everly, 1986). Lastly, CISM is *multi-component*, meaning many crisis intervention elements are intermingled (Mitchell & Everly, 1986).

The concept of critical stress management was introduced to the emergency medical field in 1974 and later evolved to CISM in the 1980's (Mitchell & Everly, 1986). Interventions were provided to emergency medical personnel such as firefighters, police officers, military personnel, and emergency medical providers (Mitchell & Everly, 1986). This program was implemented in the early phase following traumatic incidents (Mitchell & Everly, 2000). CISM interventions are provided to: 1) alleviate the impact of the traumatic event, 2) enable "normal" recovery processes, 3) restore to normal functioning, and 4) provide appropriate referral for further evaluations, supports, or treatment services (Mitchell & Everly, 1986). It is described as "psychological first aid," yet does not replace psychotherapy treatment approaches (Mitchell & Everly, 1986). In addition to continued use among the emergency medical field, CISM has expanded to many professional fields to aide in post crisis situations (Mitchell & Everly, 1986).

**Critical incident stress debriefing.** Under the development of CISM programs, S. L. A. Mitchell developed Critical Incident Stress Debriefing (CISD) in the late 1970's/early 1980's to alleviate the stress of tragic incidents (Mitchell & Everly, 2000). The purpose of CISD is to eliminate stress of traumatic events, as well as to return to the normal functioning following the traumatic event (Mitchell & Everly, 2000). CISD can also assist in identifying individuals who may need further support systems, such as referrals for mental health treatment (Mitchell & Everly, 2000).

Debriefing services can be implemented both internally and externally. Internal debriefing is described as an informal process between an emergency medical responder and a member of the organization (Revicki & Gershon, 1996). Members of the organization can include other professionals and supervisors who have also been exposed to traumatic events and can relate to the experiences of trauma (Revicki & Gershon, 1996). Research has been conducted on the debriefing process for emergency medical responders, indicating internal debriefing as beneficial for the coping process (Revicki & Gershon, 1996). Debriefing can also be implemented externally, with outside resources providing services (Halpern, et al., 2008). External resources may include debriefing teams, mental health professionals, trained response teams, or EMS personnel.

Services are often provided to emergency medical responders and their families who experience psychological effects and mental health symptoms following a traumatic event. CISD has been the most common debriefing intervention provided to paramedics and EMT personnel for the past twenty years (Everly & Mitchell, 1999). Interventions are provided from three approaches: for the individual, for groups, and for the environment and include stress management education, mental preparation training, crisis support, and referrals for additional services (Mitchell & Everly, 2000). Group interventions include: pre-crisis education, defusing, CISD interventions, and follow up services (Mitchell & Everly, 2000). Environmental interventions include: family support services, organizational support, and communal supports (education, outreach, crisis services) (Mitchell & Everly, 2000). In addition to these interventions, CISD has evolved to include organizational support, pre-crisis preparation, and demobilization (psychological decompression technique) (Mitchell & Everly, 2000). These

services are provided by trained support teams and mental health professionals (Mitchell & Everly, 2000).

**Individual debriefing.** Individual debriefing is provided by mental health professionals utilizing a variety of counseling/psychotherapy techniques (Scully, 2011). Individual debriefing has been modified from an initial focus of brief treatment and identifying coping mechanisms, to a more modern approach such as using cognitive behavioral therapy (CBT) techniques and psychotherapy. The research on a CBT approach supports early treatment success of stress disorders including PTSD (Bryant, Moulds, & Nixon, 2003). Additional interventions to promote effective coping are exposure therapy, brief electric therapy, and eye movement desensitization and reprocessing (Chopko & Schwartz, 2009). Trained professionals within the agency or external personnel who provide crisis intervention can provide techniques and interventions.

**Group debriefing.** Group debriefing can be implemented both internally and externally. Group debriefing approaches provide emergency medical responders with the opportunity to emotionally vent to normalize experiences, identify support services, and gather information about the event for the other members of the group (Scully, 2011). A seven-phase approach is used in group CISD interventions, typically taking place within 24-72 hours following the incident (Everly & Mitchell, 2000; Mitchell & Everly, 2000):

(1) an introduction phase, (2) a fact phase, (3) a thought phase, (4) a reaction phase, (5) a symptoms phase, (6) a teaching/information phase, and (7) a re-entry phase (p. 76).

Research has identified factors that contribute to successful group debriefing interventions. Watchorn (2002) concludes that responders in a group debriefing setting who know another officer and/or the professional counselor, positively influenced whether providers attended group sessions. In another study on first responders following a natural disaster, 40%

sought group-focused mental health treatment, but a majority stated they would not have engaged in therapy without at least knowing the clinician prior (Kronenberg, et al., 2008).

**Debriefing interventions.** The literature on emergency medical responders support services provides some conflicting results (Prati & Pietrantonio, 2010). Some emergency medical providers believe CISD is helpful, while others believe it has no benefit. Studies have concluded positive effects from debriefing services (Halpern, et al., 2008; Irving & Long, 2001; Leonard & Alison, 1999; Scully, 2011; Ussery & Waters, 2006) and some literature has reported possible negative effects from CISD (Addis & Stephens, 2008; Hobbs, et al., 1996; Rick & Briner, 2000; Small, et al., 2000).

**Positive findings.** Literature has concluded many positive findings for debriefing services (Halpern, et al., 2008; Irving & Long, 2001; Leonard & Alison, 1999; Scully, 2011; Ussery & Waters, 2006). When internal supervisor support is provided, there may be a decrease in work related stress (Revicki & Gershon, 1996); however, not all agencies provide debriefing services. Regehr, et al. (2002) noted in a study on paramedics and debriefing that many paramedics indicated a lack of support from their employers and unions. In Regehr, et al.'s (2002) study, 35% of participants indicated employer support as "not at all supportive." While some paramedics and EMTs believe they do not have internal support, others believe the internal support is high. As Halpern, et al. (2008) concluded, debriefing mechanisms were most beneficial for a majority of the interviewees examined in a study. This included supervisor-debriefing support and a timeout period immediately following the event compared to CISD services provided 24 to 72 hours later (Halpern, et al., 2008). This provides first responders an opportunity to process the event immediately after it has occurred and talk with other providers who have experienced similar events (Halpern, et al., 2008).



Another example of effective debriefing is the development of a help hotline. Police officers in New Jersey developed a help hotline, COP-2-COP, for policemen following a series of police suicides (Ussery & Waters, 2006). COP-2-COP was developed to provide assessment, support, referrals, and stress management sessions by trained retired officers and professionals with relevant experience (Ussery & Waters, 2006). This helpline has answered over 12,000 phone calls since the publication of the article in 2006 (Ussery & Waters, 2006). Officers described this support as “...law enforcement officers helping other law enforcement officers...” (Ussery & Waters, 2006, p. 71). This hotline has served as a model hotline for the development of similar programs and hotlines (Ussery & Waters, 2006).

The Queensland Ambulance Service (QAS) also developed a model program for debriefing first responders after traumatic events (Scully, 2011). This program provides debriefing to officers who have been exposed to traumatic events including face to face/phone counseling, peer support programs, and referrals to outside resources (Scully, 2011). In addition to internally trained officers, mental health counselors are also employed within this program (Scully, 2011). After reviewing the program, the rate of diagnosed PTSD significantly decreased by 41% (Scully, 2011).

Much of the literature supports debriefing mechanisms. Some individuals receiving debriefing services report an appreciation for such services and indicate positive results (Irving & Long, 2001; Ussery & Waters, 2006). A study by Irving and Long (2001) concluded that participants would not have followed through with additional future services (e.g. trauma counseling) if they did not engage in debriefing shortly after their traumatic event. Engaging in future support services following debriefing may help to assist individuals in returning to normal functioning.

**Negative findings.** Although much of the literature supports debriefing mechanisms, few studies have concluded minimal benefits and risks from such services (Addis & Stephens, 2008; Hobbs, et al., 1996; Rick & Briner, 2000; Small, et al., 2000). In a paper wrote by the Institute of Employment Studies, Rick and Briner (2000) identify some possible reasons why debriefing is not always effective. As similar to other studies, such as Prati and Pietrantonio (2010), one concern is re-traumatization through reliving traumatic experiences. The concern is that discussing past traumatic events may bring about negative emotions and similar feelings as if the event was happening again. In addition to re-traumatization, some research has indicated a risk of higher likelihood of psychiatric diagnosis following debriefing. Addis and Stephen (2008) concluded debriefing was associated with higher symptoms of PTSD following a study on police officers who were required to engage in debriefing services following an incident, although this may be explained by variance accounted for by other trauma or perceived stress. Additionally, a study conducted by Hobbs, et al., (1996) concluded: “Psychiatric morbidity was substantial four months after injury, with no evidence that debriefing had helped—and, indeed, indications that it might have been disadvantageous” (p.1439). A similar study indicated debriefing as a possible contribution to poorer psychology health (Small, et al., 2000).

Crisis intervention continues to be a debated topic among many professional fields and both the advantages and disadvantages of such techniques continue to be explored. The ultimate goal of these interventions is to reduce post trauma symptoms and assist in returning to normal and healthy functioning. Further research may need to be conducted to help identify what interventions are effective among specific populations and helping professions.

One area in which crisis intervention can be implemented is at the scene of a completed suicide. Family members or members in a community who are present at the scene may be

distraught, in distress, or experiencing significant posttraumatic symptoms. Members of helping professions can provide interventions to increase stabilization and aide in providing the appropriate care to these loved ones. As this study looks at EMS experiences of arriving to scenes of completed suicides, the following paragraphs review suicide statistics, risk factors, and survivors of suicide.

### **Suicide**

The CDC defines suicide as “Death caused by self-directed injurious behavior with any intent to die as a result of the behavior” (CDC, 2015). Giddens (2009) describes suicide as “the voluntary and intentional act of taking one’s own life” (p. 1). Suicide is not a recent phenomenon, but has been noted back to many centuries ago with some of the earliest records in bible readings such as the reading in the New Testament in which Judas hung himself after betraying Jesus (Giddens, 2009). Today, suicide continues to be a major issue in all societies and does not appear to be decreasing or disappearing over time.

### **Statistics**

Some individuals suffer so deeply that they believe suicide is the only sense of relief from their current situation. Although the statistics on suicide may never be completely accurate due to underreporting and stigmatization of suicide, organizations have collected data in attempt to reduce the rates of death by suicide. About 800,000 people die by suicide each year, and even more attempt suicide annually (CDC, 2015; World Health Organization). Suicide accounts for 1.4% of all deaths worldwide, making it the overall 15<sup>th</sup> leading cause of death in 2012 (WHO, 2016). In the United States alone, an average of 30,000 individuals die by suicide each year (NAMI, 2016; Rudd, Rajab, Dahm, 1994; Sudak, et al., 2008).

## **Risk Factors**

The literature has identified risk factors that contribute to suicide. There are a variety of biological, psychological, and social factors that may contribute to an individual's decision to end their life (Motto, 1978). Researchers have identified common themes and patterns in hopes to reduce the rates of completed suicides. The following is a brief review of the literature on risk factors of suicide.

**Demographic factors.** Various organizations collect data on suicide statistics based upon location, ethnicity, race, sex, and age. This paragraph provides demographic statistics on the findings of data collection conducted by organizations such as the WHO (2016) and the CDC (2015). About 75% of suicides occurred in low and middle-income countries in 2012 (WHO, 2016). The CDC found that during 2005-2009, the highest suicide rates were among American Indian/Alaskan Natives with an average of 17.48 suicides per 100,000 and Non-Hispanic Whites with an average of 15.99 suicides per 100,000 (CDC, 2015). The CDC concluded that during 2005-2009, the highest suicide rates for males was between the ages of 25-64 and were among Non-Hispanic Whites with an average of 29.69 suicides per 100,000 and American Indian/Alaskan Natives following right behind (CDC, 2015). For females, the highest rates of suicide were between the ages of 25-64. Women who were Non-Hispanic Whites had an average of 8.98 suicides per 100,000, followed by American Indian/Alaskan Native females with an average of 8.36 suicides per 100,000 (CDC, 2015).

The statistics of suicide vary among age and sex. Studies have shown that suicide is the second or third leading cause of death among teens and young adults aged 15-25 (CDC, 2015; NAMI, 2016; Sudak, et al., 2008; WHO, 2016), the second among ages 25-34, the fourth among ages 35-54, and the eighth among ages 55-64 (CDC, 2015). The CDC (2015) indicates that

suicide rates among females are the highest among ages 45-54 and among males is the highest among ages 75 and older (CDC, 2015).

**Mental illness.** Many studies have shown that individuals who complete suicide have been previously diagnosed with a mental illness (Appleby, et al., 1999; Barraclough, Bunch, Nelson, & Sainsbury, 1974; Beautrais, Joyce, & Mulder, 1996; Hall, Platt, & Hall, 1999; Motto, 1978; NAMI, 2016; Robins, Murphy, & Wilkinson, 1959). Mental illnesses include a variety of diagnosis, but studies have shown that the most common mental illnesses are manic-depressive disorder or what we now call bipolar disorder (Beautrais, et al., 1996; Hall, et al., 1999; Nock & Kessler, 2006; Robins, et al., 1959), major depressive disorder (Beautrais, et al., 1996; Motto, 1978), chronic alcoholism (Appleby, et al., 1999; Robins, et al., 1959;), substance abuse (Beautrais, et al., 1996; Nock & Kessler, 2006), anxiety disorders (Beautrais, et al., 1996), eating disorders (Beautrais, et al., 1996), and aggressive disorders (conduct disorder and antisocial personality disorder) (Beautrais, et al., 1996; Nock & Kessler, 2006). Symptoms associated with mental health illnesses are often reported by participants involved in studies following suicide attempts which include feelings of sadness/depression (Hall, et al., 1978; Motto, 1978) hopelessness (Hall, et al., 1999; Motto, 1978), insomnia (Hall, et al., 1999; Motto, 1978), anhedonia (Hall, et al., 1999; Motto, 1978), and anxiety and panic attacks (Hall, et al., 1999)

**Substance use.** Alcohol and substance use have been a common theme among individuals in studies who have attempted suicide (Beautrais, et al., 1996; Hall, et al., 1999; Motto, 1978). One study by Motto (1978) indicated that 43% of suicide attempters were drinking alcohol at the time of their suicide attempt and 20% were using alcohol, substances, or psychoactive medications at the time of their attempt. Another study indicated 59% of individuals had substance abuse history prior to their suicide attempt (Hall, et al., 1999).

**Psychiatric Treatment.** Studies show that many individuals who have completed suicide were previously or currently engaging in mental health treatment at the time of their attempt (Appleby, et al., 1999; Frances, Franklin & Flavin, 1987; Motto, 1978; Robins, et al., 1959). One study concluded that 83% of participants had made some form of contact with a healthcare provider within a month of their suicide attempt and about half of them were not asked about their emotional state by their health care provider (Motto, 1978). About 41% were under the care of a mental health provider (Motto, 1978). One study concluded that as high as 80% of individuals who completed suicide were currently prescribed a psychotropic medication at the time of their death (Barraclough, et al., 1974).

**Suicide intent.** Suicidal thoughts, intentions, and plans have been studied among individuals who have attempted suicide and survived. Many studies indicate that individuals who attempt suicide have no specific plan in place but rather it is an impulsive act (Hall, et al., 1999; Motto, 1978). A study conducted by Motto (1978) indicated a majority of individuals did not have a specific suicide plan, but rather had fleeting thoughts of suicide or no suicidal thoughts at all prior to their suicide attempt. In this study, only 29% of patients had suicidal thoughts prior to their suicide attempt (Motto, 1978). Another study found similar results, indicating only 16% of individuals had a suicidal plan, 14% of individuals had suicidal ideations prior to their suicide attempt, and that a majority of individuals attempted suicide on impulse (Hall, et al., 1999). Other studies have indicated that thoughts and hints about suicide are expressed prior to the attempt (Shneidman, 1965). Hall, et al., (1999) also found most patients indicated transient suicidal ideations prior to their suicide attempt. Some studies indicate a history of suicide attempts, while others indicate no history of suicide attempts. Hall, et al., (1999) found only one third of individuals in their study who had attempted suicide had prior attempts.

**Family History.** Mental health professionals may assess for family history of suicide with individuals presenting with suicidal thoughts. Some studies indicate that individuals who complete suicide have higher rates of having family members who have completed suicide (Hall, et al., 1999). Qin, Agerbo, and Mortenson (2002) concluded in their study that suicide risk is associated with both psychiatric hospital admissions for mental health related issues and completed suicides in family members which include the father, mother, and siblings. Other researchers have concluded that there is no correlation between the two (Motto, 1978). One study conducted by Hall, et al., (1999) indicated that 84% of patients who attempted suicide did not have a family history of suicide attempts or completions. Another study indicated that of 100 patients following a suicide attempt, only 9 indicated family history of suicide attempt and completions (Motto, 1978).

**Support System.** Lack of support systems or conflict with supports can be common risk factors among individuals who have attempted suicide. Rudd, et al. (1994) indicated that having limited support systems result in minimal coping abilities with their mental illness. In a study conducted by Motto (1978), 78% of individuals reportedly had conflict in a family, spousal, or other relationship prior to their suicide attempt. Other studies have showed similar findings, indicating conflict among family relationships prior to their suicide attempt (Hall, et al., 1999). Motto (1978) indicated that 76% of individuals did have a support system that they could have contacted prior to their suicide attempt, but did not.

## **Methods of Suicide**

Studies have been conducted to look at the methods of suicide and common themes have been identified among males and females (Appleby, et al., 1999). According to the CDC, during 2005-2009, the most common method of suicide occurred by firearms among males in each age

groups: 10-24 (49.7%), 25-64 (51.9%), and 65 and up (79.1%) (CDC, 2015), while other studies have indicated hanging as the most common method (Appleby, et al., 1999). Aside from males, the most common suicide methods among females varied among age groups (CDC, 2015). Among females, suffocation was the most common method between ages 10-24 (48.5%) and poisoning was the most common method among ages 25-64 and 64 and up (42.8% and 36.1%) (Appleby, et al., 1999; Beautrais, et al., 1996; CDC, 2015).

### **Survivors of Suicide**

Survivors of suicide can mean both those individuals who have attempted suicide and have survived, or to the family and friends of those who have lost a loved one to suicide (McIntosh, 1993; Smolin & Guinan, 1993; Sudak, et al., 2008). There is less attention given to the survivors of suicide, which is estimated as six to eight individuals for every one of the 30,000 completed suicides in the United States each year (Berman, 2011; Smolin & Guinan, 1993). Survivors of suicide who had significant relationships with the deceased, such as spouses, parents, and children, are most affected by the loss (Mitchell, et al., 2004).

The literature concludes that individuals suffering from grief from the loss to suicide are more likely to experience a phenomenon called “complicated grief” (Bailey, et al., 1999; Mitchell, et al., 2005). They describe feelings of abandonment (Bailey, et al., 1999), rejection (Bailey, et al., 1999; Harwood, Hawton, Hope, & Jacoby, 2002), and guilt (Harwood, et al., 2002; Sudak, et al., 2008). One study indicated that children of the deceased are most likely to have symptoms of complicated grief, as opposed to other significantly close relationships, such as parents and spouses (Mitchell, et al., 2004).

In addition to the natural feelings of grief and depressive symptoms from loss, survivors of suicide are often left with their own mental health concerns (Mitchell, et al., 2005; Smolin &



Guinan, 1993) and physiological issues (Mitchell, et al., 2004). Some may experience changes in sleep patterns, difficulty performing tasks, disconnect from friends and family, increased use of drugs and alcohol, and suffer from mental health issues (Smolin & Guinan, 1993). Symptoms of depression and feelings of loneliness are reported as significantly higher among those experiencing bereavement from suicide as opposed to natural bereavement (De Groot, De Keijser, & Neeleman, 2006). Studies have shown that suicidal ideations and suicide attempts may be reported among some suicide survivors (Bailey, et al., 1999; Mitchell, et al., 2005). A study conducted by De Groot, et al., (2006) in the Netherlands, indicated that 6.5% of suicide survivors had attempted suicide, which is higher than the average rate of suicide attempts among the adult general population at 2.95%.

Suicide attempts and completions continue to be a concern among all populations and all areas. There has been an increasing amount of individuals presenting to the emergency room with significant mental health concerns (Shaban, 2006). EMS personnel are often responsible for transporting individuals with mental health issues to local hospitals. The training among EMS personnel in responding to mental disturbance calls is minimal. The next section is a review of the literature on EMS responding to mental disturbance calls.

### **Responding to Mental Disturbance Calls**

Recognition and management of mental health related issues are a concern for all medical providers (Shaban, 2006). EMTs and paramedics are faced with increasing challenges as individuals presenting to emergency rooms with mental health concerns continue to increase (Shaban, 2006). EMS personnel are often responding to mental disturbance calls with individuals who have significant mental health issues and the lack of training on mental health provided to

emergency responders is a concern (Shaban, 2006). The need to provide effective care to this population is critical (Shaban, 2006).

The population of individuals presenting with mental health issues varies from males, females, children, adolescents, adults, and elders (Nusbaum, Cheung, Cohen, Keca, & Mailey (2006). However, the research shows that elderly males are the highest population to complete suicide (Nusbaum, et al., 2006). First responders are a good resource in assessing the elderly population of who may be at risk; however, screening is not typically conducted by first responders (Nusbaum, et al., 2006). Nusbaum et al. (2006), states that the elderly population is often at risk to harming themselves and attempting suicide. There appears to be a need for research to be conducted on emergency medical responders assessing and screening individuals for mental health related issues or potential suicide threats.

In a study conducted by Pajonk, Bartels, Biberthaler, Bregenzer, and Moecke (2001), an estimated 33% of mental health related calls to ambulance companies were suicide attempts or ideations by adults of all ages (Shaban, 2006). In this study, paramedics rated the importance of psychiatric knowledge as high, but stated there is lack of knowledge in working with individuals presenting with mental health concerns (Shaban, 2006). Despite the lack of knowledge in mental health related issues, a majority of the paramedics reported an interest in training to increase knowledge about psychiatric disorders (Shaban, 2006).

Training opportunities of psychiatric disorders for emergency responders are provided in some areas (Teller, Munetz, Gil, & Ritter, 2006). Partnerships between police departments and mental health agencies provide training to officers responding to mental health calls (Teller, et al., 2006). An example of this collaboration is the crisis intervention team (CIT), which provides mental health training to officers in preparation to responding to mental health calls (Teller, et

al., 2006). The results of the impact of this study suggested collaborations between police departments and mental health systems may help patients gain access to the services they need (Teller, et al., 2006).

### **Responding to Completed Suicides**

There is limited research on emergency medical responders presenting to calls of completed suicides. Some articles in peer-reviewed journals have mentioned the traumatization of responding to suicide as an emergency medical responder. In one study, a small percentage of EMS personnel described responding to completed suicides as “the most traumatic” due to the feelings of helplessness when arriving on the scene (Williams, et al., 2008). Another study concluded that responding to completed suicides were significantly traumatic for EMS personnel (Regehr, et al., 2002). Only one article was found that examined the experiences among police officers and responding to completed suicides. The following paragraphs review this study.

A study conducted by Koch (2010) examined the experiences of police officers responding to completed suicides. A qualitative study was conducted to examine the thoughts, feelings, actions, and challenges that police officers face when responding to completed suicides (Koch, 2010). Koch (2010) interviewed eight police officers, a coroner, a police psychologist, and a police chaplain with whom had experience and responded to a variety of completed suicides. The findings of this study concluded that police officers face difficult challenges when faced with completed suicides including lack of coping mechanisms, personal relationship issues, over-involvement, and difficulty with boundaries outside of duty work (Koch, 2010). This study helps to justify a need for further research on emergency medical responder experiences of responding to completed suicides.

Koch's (2010) study concluded that police officers are trained to rely on the role of their work to cope with difficult work stressors and situations. The coping mechanisms identified by police officers in this study included adherence to police roles, blocking feelings, humor, anger, faith, telling stories, depersonalization, investing or divesting, engaging or disengaging from suicide survivors, and preparedness/alertness/adrenaline (Koch, 2010). Despite the lack of training provided, all the participants in Koch's (2010) study were in agreement of mental health training. However, the participants all agreed that the provider of debriefing must be an individual who has been to a similar event, or they would not engage in this type of service (Koch, 2010).

Many of the participants in Koch's (2010) study were in agreement that the 'culture' of police work is to disengage from feelings and remain resistant to emotion. Officers typically believe showing emotions may be portrayed as a sign of weakness or inability to perform their work effectively (Koch, 2010). However, despite this role of a police officer, they are still exposed to difficult scenes when responding to completed suicides and may experience significant psychological symptoms following such events, "The smells are repellant, and officers want no part of them, they want to get away from them but are unable to do so, and it is bothersome that they cannot avoid them" (Koch, 2010, p. 94).

Koch (2010) explored the coping mechanisms officers used in responding to completed suicides. Some officers described feelings of helplessness when responding to a completed suicide because their action-oriented role to help solve crimes cannot be used (Koch, 2010). Some reported feelings of anger, as officers believed completion of suicide was a selfish act due to leaving behind friends and family (Koch, 2010). Despite some of the officer's feelings of helplessness and anger, some of the officers used prayer as a coping mechanism to relieve

feelings of helplessness and anger (Koch, 2010). Half of those officers who used prayer attempted to learn about the individuals who committed suicide to help understand why the person chose to commit such an act (Koch, 2010). The other half of the officers preferred to avoid learning about the victims and why they chose suicide (Koch, 2010). Half of the officers reported an interest in providing emotional support to family members while the other half believed this type of support was beyond their scope of practice (Koch, 2010). Koch (2010) did not elaborate on what mechanisms police officers used to help provide emotional support to family and loved ones of the deceased who were present.

The study conducted by Koch (2010) added to the literature of emergency medical responders and the mental health field. It appears police officers have conflicting thoughts regarding coping mechanisms and debriefing interventions of responding to completed suicides. Further research needs to be conducted to understand police officers and other emergency medical responders' experiences when arriving to completed suicides.

### **Presence of Loved Ones**

As Koch's (2010) study indicated, some emergency medical responders at traumatic scenes are interested in helping family members left at the scene of a completed suicide. However, Koch's (2010) study did not indicate any mechanisms in which officers used, when assisting loved ones at the scene of a completed suicide. After a thorough review of the literature, there appears to be a gap in the literature on emergency medical responder's experiences of providing aid to loved ones at the scene of traumatic events.

There appears to be a significant amount of literature on the presence of family and loved ones during emergency medical interventions. However, there is minimal literature on presence of loved ones during a traumatic event or at the scene of a loss of a loved one. For the purposes

of this qualitative study, the term “loved ones” is used, as opposed to “family presence,” in order to include all loved ones of the deceased. Since there does not appear to be any specific research conducted on presence of family and loved ones during traumatic events or at the scene of the loss of a loved one, the following is a review of the research that has been conducted on the presence of loved ones during emergency medical interventions.

With the support from professional organizations, such as the Emergency Nurses Association (ENA) (MacLean, et al., 2003; Williams, 2002) and the American Association of Critical-Care Nurses (2010), views on family and loved ones presence during emergency medical services are changing. According to the AACN (2010), the expected practice is for family members of patients undergoing invasive procedures and CPR, to be given the option to be present at the patient’s bedside. In addition, the expected practice is for all patient care units to develop an approved written policy providing the option for family presence during invasive procedures or CPR (AACN, 2010). Some research has concluded that family presence during invasive procedures and CPR is beneficial to the patient, their family members, and to the emergency medical providers (AACN, 2010).

With the support from professional organizations, the presence of loved ones during medical interventions, such as CPR and other invasive procedures (chest tube insertion, central line placement, and lumbar puncture) (Mangurten, et al., 2005) continues to be a controversial topic among the emergency medical field due to various views and thoughts about how it may *impact* medical care (MacLean, et al., 2003). Despite what appears to be limited research on the *impact* that presence of family members and loved ones has at medical interventions, much of the research has supported presence of loved ones during such events (Maclean, et al., 2003; Madden & Condon, 2007; Williams, 2002). Participants in Madden and Condon’s (2007) study

(critical care and emergency room nurses) indicated beliefs that presence of family members and loved ones during emergency medical interventions can provide them with a better understanding of what occurs during these interventions (Madden & Condon, 2007) and provide open communication between the medical providers and family members (Ellison, 2003). While some of the research supports this phenomenon, other research has identified concerns regarding family presence as well (Ellison, 2003; Fernandez, et al., 2009; Madden & Condon, 2007). The concerns reported by medical providers include violating confidentiality and privacy of patients, family interference with the medical interventions being provided, legal concerns, conflict between the emergency team, increased stress levels among the emergency team, and interference with job performance (Ellison, 2003; Fernandez, et al., 2009; Madden, & Condon, 2007).

The research suggests that many nurses are supportive of presence of family and loved ones during emergency medical services. Maclean et al., (2003) conducted a study on critical care and emergency room nurses “family presence” practices. None of the nurses who participated in this study had written policies of family presence during CPR and other invasive procedures in their health setting, but were allowed to provide family members with the option of being present (Maclean et al., 2003). As found in other studies (Madden & Condon, 2007), most nurses (75%) in the study supported family presence during most medical interventions (Maclean, et al., 2003). An interesting finding in this study was that family members often requested to be present during invasive medical interventions (61% of participants), but lower requests to be present during CPR (31% of participants). It is unclear as to why family members are less likely to request presence during CPR (Maclean, et al., 2003).

Some nurses and emergency medical providers are uncertain about the presence of family and loved ones during times of emergency medical interventions. In a study conducted by Ellison (2003), less than half of the nurses were agreeable to having family and loved ones present. Concerns among the nurses included: lack of knowledge, trauma exposure, interference with staff, overcrowding the area, susceptibility to infection, and inadequate staff (Ellison, 2003). This is similar to Fernandez et al.'s (2009) study that reviewed physicians' perspectives of family presence. This study identified concerns regarding the outcome of medical interventions. Although there does not appear to be any studies that review patient outcomes, the study suggested that physicians' thoughts on family presence could affect the medical care provided (Fernandez, et al., 2009). A concern that Fernandez et al.'s (2009) indicated was that "medical resuscitation may have been delayed due to an overt reaction from a family member" (p. 1958). Many participants suggested that emotionally distraught family members should not be present during emergency medical interventions due to the concern that their emotions may affect the treatment provided (Fernandez, et al., 2009).

Although there is existing literature on family presence during medical interventions, the lack of research conducted on family presence during other traumatic events results in a gap in the literature. The study I am conducting can provide a unique look to the trauma field. The following is a review of the theoretical foundation of this qualitative study, followed by a more in-depth look at the methodology in which this study entails.

### **Theoretical Foundation of the Study**

Van Manen's (1990) four existentials: lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relations (relationality), is be used as the theoretical foundation of this qualitative study. The existentials guide my phenomenological writing as I



acknowledge individual experiences of this particular phenomenon as a “whole” experience (Dowling, 2007). Van Manen’s (1990) hermeneutic phenomenological approach is reviewed in the following paragraphs.

Phenomenology began in Germany as a philosophical approach prior to World War 1 and continues to be common in modern philosophy (Dowling, 2007). Phenomenology was founded by Edmund Husserl 100 years ago, when he became interested in the meaning of objects and events (Lindseth & Norberg, 2004). The motto of phenomenology is described as “Zu den Sachen,” meaning “to the things themselves” and “let’s get down to what matters!” (van Manen, 1990, p. 184). “Phenomenological human science is the study of lived or existential meanings; it attempts to describe and interpret these meanings to a certain degree of depth and richness” (van Manen, 1990, p. 11). Phenomenological research is human science, it is also:

*systematic*; reflecting, focusing, intuiting

*explicit*; articulates the meaning in individual experiences

*self critical*; examines own goals to accept strengths and drawbacks of the approach and accomplishments

*intersubjective*; researcher needs a participant to validate the phenomenon (van Manen, 1990, p.11)

Phenomenology as a philosophy was used by Kant and Hegel in the 18<sup>th</sup> century (Moran, 2000). However, Husserl’s approach to phenomenology was inspired by Franz Brentano who termed the phrase “descriptive psychology or descriptive phenomenology,” which motivated Husserl in his evolvement of his phenomenological approach (Moran, 2000). Husserl’s phenomenological focus is to reach an understanding of human experiences and consciousness (Valle, Kim, & Halling, 1989).

## **Hermeneutic phenomenology**

There are two approaches to phenomenology; hermeneutic phenomenology and psychological phenomenology. For the purposes of this qualitative study, I review van Manen's hermeneutic phenomenological approach. Hermeneutic phenomenology has been described by van Manen as "oriented toward lived experience (phenomenology) and interpreting the "texts" of life (hermeneutics)" (Creswell, 2013, p. 79).

Heidegger, like Husserl's hermeneutic phenomenological approach, focuses on the human experiences as they are lived (Dowling, 2007). However, Heidegger's view on phenomenology is slightly different than Husserl. Influenced by Soren Kierkegaard, founder of existential philosophy, Heidegger is one of the first to implement existentialism with phenomenology (Valle et al., 1989). Heidegger differs in his view on exploring the lived experiences of individuals and he supports hermeneutic phenomenology as a research activity on viewing the lived experience as an interpretive process (Racher & Robinson, 2003). Heidegger remarks, "Being-in-the-world" is a term to refer to human action, existence, and involvement in the world (van Manen, 1990).

## **Chapter Summary**

I have included the most recent literature on emergency medical responder's exposure to traumatic events, loved ones presence, and response to completed suicides. The literature review provides an overview of the phenomena to be studied in this qualitative study. It is important to address the phenomena in chapter two of this study to provide an overall background of these concepts. Each concept has been studied in the literature, but has not been yet been explored in the ways this study does. The following chapter describes the methodology behind this research study.

## **Chapter III: METHODS**

### **INTRODUCTION**

This qualitative study uses van Manen's (1990) hermeneutic phenomenological approach to the inquiry. The design of this qualitative study was chosen after a thorough review of the literature on traumatic exposure of EMS personnel. In the review of the literature, much of the existing literature focused on EMS personnel's exposure to trauma (Clohessy, Ehlers, & Anke, 1999; Perrin, et al., 2007; Regehr, et al., 2002; Ussery & Waters, 2006) and debriefing mechanisms and crisis intervention mechanisms to assist in coping and returning to normal functioning (Mitchell & Everly, 1986; 2000; Revicki & Gershon, 1996). Gaps in the literature exist regarding EMS personnel who arrive to mental disturbance calls, such as completed suicides, where loved ones of the deceased are present. Therefore, the phenomenon to be explored in this study is the multifaceted traumatization of the direct and vicarious traumatic exposure experiences of paramedics and EMT's who respond to completed suicides where the loved ones of the deceased were present. This phenomenon could not be examined through quantitative methods as so little is known regarding the subject and there is nothing yet to be measured. Therefore, a qualitative approach was chosen to provide participants an opportunity to tell their stories through their own words. The methodology, purpose, research design, data collection, and explication of data are reviewed throughout this chapter.

Van Manen's (199) hermeneutic phenomenological methodology provides participants with the opportunity to describe their experiences in their natural environment. Van Manen (1990) describes hermeneutic phenomenology as an opportunity to give *meaning* to human experiences. This qualitative approach attempts to understand individual's perspectives and understandings of their personal experiences (van Manen, 1990). Van Manen (1990) states

“...phenomenology is the systematic attempt to uncover and describe the structures, the internal meaning structures, of lived experience” (p. 10).

### **Purpose of the Study**

The purpose of this qualitative study was to explore the lived experiences of EMS personnel who respond to scenes of completed suicides where loved ones of the deceased were present. I chose to conduct a qualitative study, as the essence of this study was to understand the experiences that EMS personnel describe with this phenomenon, which cannot be obtained through quantitative methods. There is voluminous research on the psychological effects that traumatic events can have on EMS personnel, however, there is limited research on their direct experiences to completed suicides, and the presence of loved ones of the deceased.

Van Manen’s (1990) hermeneutic phenomenological approach and the descriptions of EMS personnel’s lived experiences of responding to completed suicides with loved ones present provides implications for multiple fields. EMS personnel, first responders, mental health professionals, crisis response members, and other helping professional fields can be impacted by this type of study. In gaining an understanding of the experiences of EMS’ direct and vicarious traumatic exposure, this study can support the emergency medical response field in improvement of training mechanisms in responding to mental disturbance calls. In addition, this study can also increase effective debriefing mechanisms or implementation of support mechanisms for the field of emergency response workers by understanding their lived experiences.

### **Research Design**

Using a qualitative research design, this study offered a unique opportunity to understand EMS personnel’s experiences of multifaceted traumatization, identified as both direct and vicarious traumatic exposure. Qualitative research provided an opportunity to capture

participants lived and real life experiences with multifaceted traumatization. With qualitative data explication, themes and issues were identified that could be later examined using quantitative designs.

Van Manen's (1990) hermeneutic phenomenological qualitative design helped to explore the phenomenon of EMS personnel's lived experiences when responding to completed suicides. In addition, the experiences of vicarious exposure with loved ones of the deceased present were also explored. Individual interviews were conducted using a semi-structured format, to provide participants with the opportunity to describe their experiences of the phenomenon being studied.

### **Qualitative Inquiry**

A qualitative design is used in this study, as opposed to a quantitative approach, because there is not enough known about the specific phenomena being studied. This qualitative study explored the meaning of phenomenon that has been overlooked in the trauma literature. Creswell (2013) states that a qualitative approach is used to make a specific phenomenon clear and to gain understanding and interpretation of how participants construct the phenomenon (Glesne, 2006). Qualitative research can understand how humans "arrange" and make sense of themselves and their settings (Berg, 2007). This study is set to understand the experiences of EMS personnel who describe arriving to completed suicide scenes where loved ones of the deceased were present.

### **Sample**

Purposeful sampling and snowball sampling methods were used to recruit paramedics and EMT's for this study. As opposed to quantitative research, which tends to use random sampling methods, qualitative researchers typically use purposeful sampling, in order for researchers to select "information-rich cases" (Patton, 2002, p. 46). The purpose of qualitative

research is not to generalize information to larger populations, but to learn about the central focus of the phenomenon being studied (Patton, 2002). To expand recruitment, snowball-sampling methods were also used.

**Purposeful sampling.** Purposeful, criterion, sampling was used for this qualitative study. Berg (2007) identifies purposive sampling as a method of selecting participants who represent the phenomenon being studied. In the first step of selecting participants, I contacted local ambulance services and spoke with the directors or supervisors of the agency in order to recruit EMS personnel. I reviewed the informed consent, as further described in the following paragraph, to the directors or supervisors, and prepared for any questions, concerns, and issues that they may have had (Glesne, 2006). If gatekeepers were agreeable for participation, I asked if recruitment letters and flyers and informed consents could be brought to their agency or emailed to them to be placed in a common area for potential participants to see.

**Snowball sampling.** Snowball sampling was also used for this qualitative study. Snowball sampling is used when the researcher recruits potential participants by receiving contact information provided by participants (Noy, 2008). Snowball sampling is one of the most widely used sampling methods in qualitative research across the social sciences (Noy, 2008). Some participants contacted me after reviewing the informed consents and recruitment flyers at their areas of employment. Those who had agreed to participate were asked for referrals to other EMS personnel who they believe may have also experienced the same phenomena being studied. I followed up with these individuals to see if they would be willing to participate in the study.

An informed consent, also known as a lay summary, is a presentation to potential participants regarding the purpose and specifics of the study (Glesne, 2006) and was provided to each participant. The informed consent included: who I am as a researcher, the purpose of the

study, what would happen, what would happen with the results, selection of participants, risks and benefits to participants, confidentiality, frequency and duration of interviews, and requests for audio recording of interviews (Glesne, 2006). The informed consent provided an opportunity for participants to ask questions and receive answers (APA, 2010).

### **Selection**

With permission of agency gatekeepers, EMS personnel were recruited through a recruitment letter and flyer that were taken or emailed to local ambulance companies in Ohio and Pennsylvania. In order to gain permission, I contacted the local agencies and asked for permission to place the recruitment letter and flyer within their agency. The recruitment letter and flyer described the following:

- (1) the researcher, which included that I am a doctoral candidate at Duquesne University in the Counselor Education and Supervision program and my contact information
- (2) purpose of the study, which included the title of this qualitative study, the sample to whom I was hoped to talk (EMS personnel who have responded to completed suicides)
- (3) copies of the informed consent, which included: who I am as a researcher, the purpose of the study, what would be happening, what would happen with the results, selection of participants, risks and benefits to participants, confidentiality, frequency and duration of interviews, and requests for recording of interviews.

In order to participate in this study, participants had to meet the following criteria: be certified as a paramedic or EMT, at least 18 years of age, have been an employed or volunteer paramedic or EMT for at least one year, and have responded to a suicide where loved ones of the deceased were present. As mentioned in an earlier chapter, emergency medical personnel have titles based upon their level of education and care provided to patients (NREMT.org). There are

four levels of EMS personnel: emergency medical responder, emergency medical technician, advanced emergency medical technician, and paramedic (NREMT.org). All levels of care provide lifesaving care to patients with critical concerns (NREMT.org). Emergency medical responders have the basic knowledge and skills to initiate emergency care while awaiting for additional EMS personnel to arrive to the scene (NREMT.org). Emergency medical technicians (EMT) hold the basic knowledge and skills, and provide basic emergency medical interventions and transportation to the emergency medical system with equipment typically found on an ambulance (NREMT.org). The advanced EMT is similar to the EMT but can also provide basic and limited advanced emergency medical care and transportation (NREMT.org). Paramedics provide advanced emergency medical care for critical patients (NREMT.org). Their training includes complex knowledge and the skills necessary to provide advanced patient care and transportation (NREMT.org).

### **Data Collection**

Data was collected through semi-structured individual interviews, researcher field notes, and analytic notes. I began data collection by conducting audiotaped, semi-structured, face-to-face, individual interviews with all willing participants. The sample of participants included 12 individuals who identified themselves as EMS personnel. The interviews were held in a private location identified with each participant and took approximately one hour, but more time was allotted if needed. Once the interviews were completed, I transcribed the data collected verbatim. Each transcript was given back to the participant to ensure accuracy. I then explicated data by examining the transcripts and identifying themes among participant responses. I used van Manen's (1990) four existential themes (corporeality, spatiality, temporality, and relationality) in



explication of the data. This theoretical framework was used to give meaning to human experiences.

### **Individual Interviews**

“We gather other people’s experiences because they allow us to become more experienced ourselves” (van Manen, 1990, p. 62). In order to gather lived experiences, data was first collected through individual interviews. I contacted local ambulance agencies in Ohio and Pennsylvania to describe the purpose of my study. With permission of the ambulance agencies, I placed recruitment letters and flyers and copies of informed consents in these agencies, which described in detail the purpose of the study, who I am as a researcher, and my contact information.

I reviewed the study with participants who contacted me and were agreeable to participating in the study. Those EMS personnel who were interested in participating and who met the study parameters (identified as an employed or volunteer paramedic or EMT and have worked or volunteered for at least one year, have responded to at least one suicide, were over the age of 18, and were willing to participate in the study) were asked to meet for an interview. All participants were informed that we would meet for an approximate one-hour individual interview at a private location identified in collaboration with the participant. When a sufficient number of interviews were conducted so that the data has reached the saturation point, any further inquiries regarding participation were thanked and informed that the study had been completed.

Semi-structured individual interviews were audiotaped and conducted face-to-face in a private setting, identified in collaboration with participants. The time of the semi-structured interviews was approximately one hour. Participants were informed that interviews might be less or more than the expected time. The identified research questions were asked during individual

interviews and participants were encouraged to elaborate on their experiences. All audiotapes were kept in a locked cabinet in the researcher's home office unless being used for transcription. Upon completion of individual interviews, the audiotapes were transcribed by the student co-investigator for data explication and locked in the cabinet with the audiotapes. Only the researcher had the key to the locked cabinet. The transcripts were numerically coded to protect participant's names. Following completion of this study, the audiotapes were destroyed to protect participants' confidentiality and transcripts will be kept in a locked cabinet for five years.

### **Interview Questions**

Prior to starting the interview, all participants were asked to complete a demographic survey. The following questions were asked in the demographic survey:

- (1) What is your job title?
- (2) What is your training?
- (3) What is your certification or licensure?
- (4) How many years of experience do you have in this position?
- (5) Approximately how many suicides have you responded to in your position?
- (6) Do you have any personal experience with a suicide of a loved one? Yes \_\_\_\_ No \_\_\_\_
- (7) What is your age?
- (8) What is your ethnicity?
- (9) What is your gender?

Following completion of the demographic survey, the individual interviews were conducted. Research questions were developed based upon the phenomenon being studied: Multifaceted Traumatization: Direct and Vicarious Exposure of EMS Personnel Who Responded To a Suicide Where Loved Ones of the Deceased Were Present. To provide an opportunity for

participants to describe their experiences with this phenomenon, I identified a set of questions that were used as the foundation of the semi-structured individual interviews. The following questions were asked:

1. Please describe your experiences of responding to completed suicide calls?
2. Please describe the ways in which you were impacted by suicide calls?
3. Please tell me about what it was like to have the deceased's loved ones present when you responded to a completed suicide?
4. How do you make sense of your continued direct exposure to traumatic events?
5. How do you make sense of witnessing loved ones direct exposure to traumatic events?
6. How do you sustain your work as an emergency medical services personnel?

### **Field Notes/Analytic Notes**

In addition to individual interviews, I collected field notes during the individual interviews. This was made known to all participants, as Glesne (2006) recommends. Glesne (2006) identifies a field book as “the primary recording tool” (p. 55) in qualitative research. Field notes can be used for multiple reasons: to explain participant descriptions, to identify emerging patterns, a form of reflection of ideas (Glesne, 2006), and documenting expressions from participants that may not be captured with audiotapes. I took notes throughout the interviews and expanded on the notes within the same day to ensure that I was as accurate as possible in recalling the information as a time lapse between the individual interview and further expansion of notes may lead to inaccurate information (Glesne, 2006). Glesne (2006) encourages field notes be both “descriptive and analytic” (p. 56), as well as accurate and nonjudgmental. In-depth details of the experiences provided a visual for readers, and myself as the researcher, as time lapsed from conducting the research (Glesne, 2006).

I also used analytic notes after completion of individual interviews. Analytic notes are defined by Glesne (2006) as things that occur to the researcher following data collection. They can be completed following interviews and can serve as a tool for reflection including feelings, impressions, interpretations, and upcoming plans (Glesne, 2006).

Data collection was concluded following completion of 12 individual interviews. At this time, saturation was met, as there did not appear to be any new information obtained from the data. Themes emerged from participant's narratives and all participants identified unique descriptions of their experiences.

### **Instrumentation**

With facilitation of interview questions, observations, and interactions with participants, the researcher is the primary instrument in qualitative research (Glesne, 2006). According to Krathwohl & Smith (2005), one of the essentials in a qualitative study is for the researcher to review and cover their qualifications. I have provided a description of my professional career experiences and personal interest in this qualitative study in the following paragraphs.

#### **Researcher as Instrument**

I have been working in the mental health field since completion of my clinical counseling Masters program in 2010. In my first position as a counselor, I was employed in an outpatient counseling agency in northeastern Ohio, engaging in the diagnosis and treatment of mental and emotional disorders. I provided counseling services to various populations including children, adults, and the elderly. In the two years that I was employed in this agency, the settings included an in-office caseload, in-home therapy, a public school, and an alternative school setting. During this experience, my interest in trauma developed as many of my clients presented with stories of traumatic exposure. I became aware that traumatic events occur across a diverse setting including

gender, various ages, races, ethnicities, and socioeconomic statuses. I became passionate about the experiences in which many of my clients described during our time in counseling sessions. What noticeably stood out to me was the resiliency that many clients described following a single or complex history of traumatic events.

I chose to further my education and was accepted into Duquesne University's Counselor Education and Supervision doctoral program. I moved from northeastern Ohio to western Pennsylvania to complete this program. During my doctoral internship, I worked in a Behavioral Health Rehabilitation Services Program in a community based mental health agency with children diagnosed with autism spectrum disorder. This experience was unlike my previous employment in an outpatient mental health agency. I was thankful for this opportunity, but after completion of my internship I chose to return back to working with individuals in an outpatient treatment facility.

After completion of my doctoral classes, I moved back to northeastern, Ohio and have been working at an outpatient health center, treating and diagnosing mental and emotional health disorders. I work with a diverse population presenting with various mental health concerns and traumatic exposure experiences. This experience has validated my reason for conducting a qualitative study on direct and vicarious traumatic exposure experiences.

Throughout my doctoral program, I continued to feel passionate about exposure to trauma and I planned to complete my dissertation study on emergency medical responder's exposure to trauma. My interest in traumatic exposure among EMS personnel developed during my first job as an outpatient mental health counselor. During this position, my two supervisors, I, and other counselors would often respond to crisis situations in the local community. During one crisis response call, we arrived to local schools after a house fire killed a family of five,

including three children who were enrolled in two of the local elementary schools. I provided debriefing services and crisis mental health interventions for school employees and students. My supervisor provided debriefing services to the EMS, who had responded to the house fire and had attempted to revive the victims. I remember wondering how those first responders would ever be able to cope with those images and continue their role as an emergency medical responder. I questioned whether this direct trauma exposure was similar to the vicarious exposure that I experienced as a counselor through hearing continuous stories of clients' traumatic events.

I began reviewing the literature on emergency medical responder exposure to trauma at the time of the doctoral comprehensive examination, where I was encouraged to narrow my focus of studies by identifying gaps in the literature. Through my review of the literature, I found limited information on EMS personnel arriving to mental disturbances calls. Specially, I found very little research on emergency medical responders arriving to scenes of completed suicides. I found only one peer reviewed journal article that described police officers who arrived to completed suicides. After acknowledging the gaps in the literature on EMS personnel and suicide, this helped to narrow my research focus.

I believe my personal experience over the years in working at outpatient mental health agencies has given me some insight into the world of multifaceted traumatization and can be an addition to this study. However, I am aware that my personal experiences and assumptions may leave room for potential bias during this study. In order to reduce the bias that I experience, I continued to consult with my dissertation chair and committee and reflect on my personal experiences.

## **Ethical Considerations**

After completion of the dissertation proposal defense, this dissertation proposal was submitted to the Institutional Review Board (IRB) at Duquesne University for approval. After receiving approval from the IRB, data collection began. Ethical considerations were reviewed with the dissertation chair and committee prior to data collection and were considered throughout the entirety of the study.

### **Treatment of Participants**

The informed consent was presented to each participant prior to participation in the study. The American Psychological Association (APA) (2010) Ethical Principles of Psychologist and Code of Conduct, Standard 8, Research and Publication, requires the following when obtaining the informed consent:

- (1) the purpose of the research, expected duration and procedures
- (2) their right to decline to participate and to withdraw from the research once participation has begun
- (3) the foreseeable consequences of declining or withdrawing
- (4) reasonably foreseeable factors that may be expected to influence their willingness to participate such as potential risks, discomfort or adverse effects
- (5) any prospective research benefits
- (6) limits of confidentiality
- (7) incentives for participation
- (8) whom to contact for questions about the research and research participants' rights

In addition to the informed consent, Glesne (2006) identifies five principles to consider in appropriate treatment of participants: (1) participants must have adequate information about the

study for participants to be able to decide whether to participate, (2) participants may leave the study at any time, (3) all known risks to participants must be eliminated, (4) benefits must outweigh all possible risks, and (5) the study must be implemented by qualified researchers. These principles were also considered prior to data collection and throughout this study.

In order for participants to decide if they wanted to participate, I made sure to provide adequate information to all participants with a review of the informed consent. Participants were informed that their participation in this study was voluntary and that they could leave the interview at any time. In order to eliminate all known risks to participants, I reviewed potential risks of emotional reactions with discussing traumatic exposure experiences prior to starting the interviews. I ensured that they could leave the study if they were uncomfortable or were experiencing significant negative emotions associated with their experiences. If needed, referrals for counseling services or mental health treatment were made. The benefits of this study are the contributions to the field of EMS, mental health professionals, and other helping professions. Participants were informed that they may not receive personal gains from this study but were informed that their participation could help researchers gain a better understanding of the traumatic exposure experiences among EMS personnel. Lastly, I, a doctoral candidate, under the guidance of a dissertation chair and committee, conducted this study.

### **Confidentiality**

Participants should have the right to have their information provided in individual interviews to remain confidential (Glesne, 2006). Participants were informed that any identifying knowledge would only be known to me. None of the participants were identified in data transcriptions. All transcribed data disguised participant identities and interview locations. The informed consent contained written information on protection of participants and I verbally



reviewed these considerations prior to the individual interviews. This included: confidentiality, anonymity as a participant, data results, and breaches of confidentiality as a mandated reporter. Mandating reported laws were reviewed with all participants. Participants were also informed that any reports of harm to one self or others would result in a report to the proper authorities.

### **Data Storage and Retention**

Participants were informed that all data would be kept in a locked cabinet or password protected files in which I would only had access to. All hard copies of transcribed data were stored in a locked cabinet and electronic data was placed in password protected flash drives. Once the dissertation study was completed, audiotapes were destroyed. Transcribed data will be stored in a locked cabinet for five years following completion of this study.

### **Report of Findings**

Prior to data collection, all participants were informed that their identities would be protected in the findings of the dissertation study. Once data was transcribed, all participants were given the transcripts to review for accuracy and modifications to the transcriptions were made if participants noted inaccuracy. In addition, the findings of this study were also provided to participants if they wished to obtain a copy for their review and modifications were also made if any inaccurate findings were noted by the participants.

### **Ethics of Research on Traumatic Exposure**

There are additional ethical considerations to consider in this qualitative study. The following paragraphs identify additional ethical considerations when working with trauma-exposed populations. Individuals who have experienced significantly traumatic events in their life may have some difficulty discussing these events. During the review of the informed consent, potential risks are discussed and participants have the opportunity to decide for

themselves whether participation in this study is of their best interest (Newman, Walker, & Gefland, 1999; Seedat, Pienaar, Williams, & Stein, 2004). At this time, Briere and Scott (2013) suggest assessing the individual's current mental status and psychological functioning prior to discussion of trauma exposure. Briere and Scott (2013) advise opening up a discussion about the traumatic event in a supportive manner by asking if they are comfortable with being asked questions about their experiences and informing them that they could stop the discussion at any time. I used this language prior to the start of the interviews, which provided an opportunity for participants to choose their comfort level and what they wanted to discuss.

Although the topics being discussed during interviews may present risk of retraumatization or negative responses, these circumstances are routine in the daily world of EMS personnel. It is uncommon that having conversations about routine work creates negative feelings or retraumatization. In addition, much of the research suggests that discussing narratives of traumatic exposure experiences can be positive or therapeutic in nature (DePrince & Freyd, 2004; Draucker, 1999; Griffin, Resick, Waldrop, & Mechanic, 2003; Newman, et al., 1999; Seedat, et al., 2004; Walker, Newman, Koss, & Bernstein, 1997). "The benefits of confiding a traumatic experience to a trustworthy other, whether as a subject in the laboratory or as a participant in naturalistic research, seem to outweigh the immediate distress that accompanies discussion of painful experiences (Draucker, 1999, p. 167).

### **Explication of Data**

The approach taken to gathering and explicating the data was phenomenological in nature. Van Manen (1990) states "The purpose of phenomenological reflection is to try to grasp the essential meaning of something" (p. 77). The researcher collects data from individuals who have experienced a similar phenomenon and composes a narrative of the "essence" of lived

experiences (Moustakas, 1994). Explication of the data was completed in order to grasp meanings presented by participants and establish common themes. Van Manen (1999) (p. 78) states “Theme analysis” refers then to the process of recovering the theme or themes that are embodied and dramatized in the evolving meanings and imagery of the work.”

Themes were identified among participants’ responses using a manual thematic coding method. Glesne (2006) identifies coding as a process of sorting through the data, which includes field notes, transcribed data from interviews, and any additional data collection notes. By sorting through the data, major categories or clumps can be identified and later broken down and important themes are identified and coded with a name (Glesne, 2006). After coding was completed, they were placed in a logical order for complete explication of data (Glesne, 2006). In addition, reviewed Hycner’s (1999) five-step data explication process was used to assist in data explication:

- (1) Bracketing and reduction
- (2) Delineating units of meaning
- (3) Clustering units of meaning to create themes
- (4) Summarizing interviews
- (5) Extracting themes

### **Bracketing and Reduction**

Hycner (1985) encourages an approach to reviewing audio recordings and transcribed interviews with an open mindset for meanings to emerge. In order for meanings to emerge, I suspended or ‘bracketed’ the meanings and interpretations of data to enter the ‘world’ of the participant (Hycner, 1985). I followed through with Hycner (1999) and Holloway’s (1997)

recommendation of repeated listening of interview recordings to gain familiarity with interviewees' data.

### **Delineating**

The next step was to elicit the meaning found in participant data (Hycner, 1985). I reviewed all words, sentences, and statements, to consider the number (the significance) of how often a meaning was mentioned (Groenewald, 2004). This was done by staying as close to the literal data, known as a “unit of general meaning” (Hycner, 1985, p. 282). Transcribing my own data made this step more possible.

### **Clustering**

I then reviewed the units of meaning to see if any clustered together (Hycner, 1985). I examined each unit that was identified during delineating and found common themes among those units (Hycner, 1985). This process required continuous review (back and forth) of the transcribed data (Hycner, 1985) and again, transcribing my own data helped in this step. I was aware of personal judgment when clustering units and had the dissertation chair review the clusters as well (Hycner, 1985).

### **Summarizing interviews**

All summarized themes give the data a “holistic context” Groenewald (2004, p. 20). I went back to the transcribed interviews and provided a summary of the interviews including the themes that have been identified from explication of the data (Hycner, 1985). A “validity check” was conducted by going back to participants to ensure that the essence of participant's perspectives has been accurately captured (Hycner, 1999). If the summarization was identified as incorrect, corrections were made based upon participant responses (Hycner, 1985).

## **Extracting themes**

After completion of the above steps, Hycner (1999) suggests that the researcher look at the common themes and individual differences that have been identified by participants. While being careful to not clump themes together that had significant differences, I identified themes common to all or most of the interviews and created general themes (Hycner, 1985). In addition, I noted the unique themes identified in single interviews (Hycner, 1985). Finally, I wrote a composite summary of all individual interviews to ensure that I captured the essence of the phenomenon being studied (Hycner, 1985).

## **Limitations of the Study**

As with any study, there are potential limitations. One limitation is the sample size and generalizability among other first responders. The study was limited to 12 paramedics and EMT's, therefore it can not be generalizable to all paramedics and EMT's. Additionally, the study only consists of one population of emergency medical responders, paramedics and EMT's. Other emergency medical responders such as police officers, crisis mental health workers, and fireman were not included. Therefore, this study only describes the experiences of one population of EMS personnel and does not provide descriptions of other populations who may experience the same phenomenon. The study does not generalize to other emergency medical responder personnel.

As some participants were recruited from small towns, it is possible that some EMS personnel may have known the deceased or loved ones of the deceased at the scenes of completed suicides. These established relationships may create more intense emotional reactions for this population of EMS personnel, as opposed to traumatic scenes with individuals whom

they have never met. These personal relationships may have resulted in greater risk of developing post trauma symptoms, than responses to unknown individuals.

There are also potential limitations when interviewing participants with a history of traumatic exposure. Some emergency medical responders who have experienced traumatic events may be less willing to discuss their experiences due to various reasons, such as risk of retraumatization, difficulty recalling traumatic events, fear of emotional responses, and concern that emotional responses may affect their job or be known to others. To reduce these concerns, I conducted individual interviews only and refrained from conducting focus groups where EMS personnel may have known each other.

A final limitation to the study is my own bias as a researcher. As I described earlier, I have a deep interest in the field of emergency medical responders, exposure to trauma, and suicide. I was aware of my own personal bias and thoughts throughout the process of this dissertation. I consulted with my dissertation chair and committee throughout this process to eliminate bias in my explication of the data.

### **Delimitations of the Study**

The delimitations of this qualitative study include the choices I made as a researcher, the population being studied, and the research approach. I chose to focus my sample on paramedics and EMT personnel only, rather than including other emergency medical responders. I chose this specific population due to the gaps of information I found in my review of the literature. As I looked at the most recent literature, I found that there was little research conducted on paramedics and EMT's responding to specific events, such as completed suicides. I found one article on police officers responding to completed suicides. I learned in my review of the literature that EMS personnel are often first on the scene for mental disturbance calls, which

include completed suicides, therefore choosing this population for my sample was appropriate. After a review of the literature on presence of loved ones and in my discussion with my dissertation chair, we decided to include presence of loved ones of the deceased, as there is minimal research on the presence of family and friends at traumatic events. The literature that does exist includes loved ones presence only during medical interventions, such as CPR. Therefore, this combination of phenomena makes this study unique.

I purposefully chose van Manen's (1990) hermeneutic phenomenological methodology for this qualitative study. I wanted to capture the experiences of this specific phenomenon among participants, provide them with an opportunity for them to tell their stories and their beliefs about this phenomenon. Since there is no research on this multifaceted traumatization, it is important to gather qualitative research to provide further understandings and descriptions of such events.

### **Contribution to the Field**

I believe that this qualitative study is an important contribution to the field. If effective debriefing mechanisms, coping abilities, and effective interventions are to be developed, more information on personal experiences needs to be collected. We have a growing body of research on trauma exposure, but little information on specific traumatic events, combination of direct and indirect exposure within the same event, and loved ones presence at trauma scenes. This qualitative study may work in some ways to help improve our understanding of the impact and effects of trauma on EMS personnel to such a traumatic event, where loved ones are present. By improving our understanding of how EMS personnel are affected by this phenomenon, debriefing mechanisms, coping abilities, and interventions may be enhanced. I believe this is a goal to work toward achieving.

## **Chapter Summary**

The purpose of this study is to further understand the experiences in which EMS personnel describe as a result of their responses to completed suicides, where loved ones of the deceased were present. Since the phenomenon of multifaceted traumatization has not yet been explored, a qualitative approach was appropriate to gather the lived experiences of the participants being studied. To further guide this phenomenological qualitative approach, van Manen's (1990) four existential themes were used: lived space, lived body, lived time, and lived other.

Data was collected through individual interviews with willing participants. Participants were chosen through criterion sampling and snowball sampling methods. In addition to individual interviews, field notes, and analytic notes were also used for data collection. Data was explicated using Hycner's (1999) 5 step process: bracketing and reduction, delineating units of meaning, clustering units of meaning to create themes, summarizing interviews, and extracting themes.



## **Chapter IV: RESEARCH FINDINGS**

### **INTRODUCTION**

The findings of this study illuminate the lived experiences of paramedics and EMT's who responded to completed suicides where loved ones were present at the scene. Van Manen's (1999) hermeneutic phenomenological research approach allows for an in-depth look at the direct and vicarious traumatization among the paramedics and EMT's interviewed for this study. The data from these interviews provided rich descriptions of their experiences with multifaceted traumatization. The data was explicated through van Manen's (1990) hermeneutic phenomenological approach that drives this inquiry. In addition to Hycner's (1999) data explication process, van Manen's (1990) four existentials: lived space, lived body, lived time, and lived human relations, guided the data explication process.

This chapter provides a case-by-case narrative for each of the twelve individual interviews that were conducted for this study. In addition to the supporting statements pulled from each transcription, my field notes and analytic notes are also included in the narratives. Following each narrative, the categories derived from the data are organized into tables. These tables link the supporting statements from participants with their analytical categories and the themes that emerged between the interviews. The chapter concludes with a cross-case analysis and summary, providing the reader with a more in-depth understanding of the experiences of direct and vicarious traumatization of paramedics and EMT's. All of this material acts as an introduction to an in-depth analysis of the central themes in chapter 5.

### **Demographic Information**

There were 12 participants, who each engaged in a semi-structured, individual interview for this study. To protect participant confidentiality, participants were assigned a case number

and will be referred to by this number throughout the research findings. There were four females and eight males, ranging in age from 24-57 (with an average age of 38.9). Eleven of the 12 participants identified as Caucasian/White and one participant did not provide an answer to this question in the demographic survey. All participants were currently employed or identified as volunteer paramedics or emergency medical technicians at an ambulance company with at least one year of experience. The years of experience ranged from 7 years to 37 years (with an average of 17.6 years). Of the 12 participants, 7 identified as certified paramedics and 5 identified as certified EMT's. On the demographic questionnaire, participants were asked how many completed suicide calls they have responded to in their position as a paramedic or EMT. The range of responded suicides was from 1 to 150 (an average was not calculated due to some participants reporting a range of numbers, a question mark for this answer, or a broad answer). The participants were also asked about having personal experience with suicide in which seven participants answered "yes" and five answered "no." Table 1 provides a summary of the demographic information of participants.

**Table 1. Participant Demographic Information**

Participant Number	Age	Gender	Ethnicity	Certification	Years of Experience	Suicides Responded to	Personal Experience
1	51	Male	Caucasian	Paramedic	33	150	No
2	38	Male	Caucasian	Paramedic	20	100	Yes
3	38	Male	Caucasian	EMT	20	15	Yes
4	30	Female	Caucasian	EMT	8	40-50	No
5	56	Female	Left blank	Paramedic	25	At least 6	No
6	57	Female	Caucasian	Paramedic	37	10	Yes

7	32	Male	Caucasian / Scottish	Paramedic	10	30	Yes
8	25	Male	Caucasian	EMT	8	Dozens	Yes
9	42	Male	Caucasian	EMT	22	?	Yes
10	25	Male	Caucasian	Paramedic	10	2	No
11	24	Male	Caucasian	EMT	7	3	No
12	49	Female	Caucasian	Paramedic	11	1	Yes

### **Individual Interviews**

All interviews were semi-structured in format and were audio recorded in order to have an accurate, verbatim transcription. Throughout the semi-structured interviews, I took field notes to write down non-verbal behaviors among participants or thoughts that came to my mind during the interview. I also reflected upon my experiences with the participants and noted thoughts of significance after the completion of interviews. I conducted 12 individual interviews with willing participants from Ohio and Pennsylvania. Some participants were from small, rural towns, while others were conducted with individuals providing emergency medical services in larger, more urban cities. All interviews were conducted in a private location, such as a company office, a classroom or private room in a university. The range of the duration of interviews was from 48 minutes to one hour and 27 minutes.

### **Analysis of Individual Interviews**

After the completion of the individual interviews, all audio recordings were transcribed verbatim. I chose to transcribe the data because I felt that listening to audio recordings would bring me closer to the data and help to identify themes, patterns, and individual differences among the participants. I immersed myself in the data, and listened to the audio recordings and

read the transcriptions multiple times to become familiar with participant data. While listening to the audio recordings, I took additional notes that came to mind and placed them along the sides of the transcription. These techniques provided an opportunity for me to begin explication of the data.

Once the transcription process was completed and the tapes and transcriptions were reviewed multiple times, the data was explicated through the lens of van Manen's (1999) four lived existentials. I used Hycner's (1999) five-step data explication process to assist me in identifying participants meaning, themes, and individual differences: bracketing and reduction, delineating units of meaning, clustering units of meaning to create themes, summarizing interviews, and extracting themes.

Hycner's (1999) data explication process provided an opportunity to better manage the voluminous amount of data collected and allowed for preparation for data explication. First, bracketing and reduction, allowed me to reduce the amount of data collected. The transcriptions of the 12 participants included over 200 pages of single spaced data and reducing the data allowed for better management of the data. Next, I delineated the data by removing units of meaning that were not related to the phenomenon being studied. This provided an opportunity to begin to identify themes in each individual interview. Third, I began to cluster the units of meaning to identify emerging themes. The themes identified were categorized using van Manen's (1990) lived existentials. Fourth, I summarized the interviews with the identified themes to prepare for data explication. Finally, I extracted themes among participant interviews including common themes and individuals differences identified by participants, while careful to not clump themes together that had significant differences. The significant themes could be

organized into four general categories related to the research questions. The four major categories were as follows:

1. Lived existential (body, space, time, and relationship)
2. Risk factors
3. Protective factors
4. Meaning of Experiences

### **Case-by-Case Analysis**

This section provides a detailed description of the 12 interviews conducted in the order that they occurred. Each description includes a case-by-case analysis of the participant's experiences with the phenomenon being studied. These narratives illustrate the four categories discussed above.

**Individual interview #1.** The first interview was conducted with a 51-year-old Caucasian male who has been in emergency medical services (EMS) for 33 years. He is currently employed part-time as a paramedic and holds another full time position where he is a supervisor. He has worked at various ambulance agencies primarily in smaller, more rural towns. As we were walking into the interview room, he discussed his role in his leadership position, but this information is not included to protect his anonymity. He informed me that he had a work cell phone that would continue to “ding” throughout the entirety of our meeting, which I emphasized that he could answer at any time and that I would be glad to wait for him to complete the phone call during our interview. He described having many areas of training, but stated that he would keep it “generic” for the purposes of this study and identified as a certified paramedic, CCT (critical care transport). In the demographic questionnaire he reported that he has responded to at

least 150 completed suicides. He did not self-identify with having personal experience with suicide on his demographic questionnaire.

The interview was conducted in a private office space after-hours at his place of employment. This room provided a quiet space in which he could openly discuss his experiences without the presence of others. He had been provided with the consent form, demographic questionnaire, a recruitment letter, and a recruitment flyer prior to our meeting. He arrived on time and I introduced myself to him and emphasized that participation in this study was voluntary and that he could leave at any time. He acknowledged voluntary participation and chose to participate in this study and joked “I think I’m handling it.” In addition to the time he spent reviewing the documents prior to our meeting, we reviewed the consent form which included: who I am as a researcher, the purpose of the study, what the interview entails, what would happen with the results of the study, selection of participants, risks and benefits to participants, confidentiality, expected duration of interview, and requests for audio recording of the interview. I informed participant #1 that I would be emailing him a copy of the transcription of the interview within a couple weeks for him to review and check for accuracy. I also let him know that I would be taking field notes throughout the interview process. I reviewed the research recruitment approach of snowball sampling and informed him that he could provide the names and contact information of paramedics and EMT’s who may be willing to participate. At this time he provided me with the names and phone numbers of three individuals. Following the review of materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form, he completed the demographic questionnaire, and then I began the interview. The interview lasted approximately 53 minutes at which the participant expressed that he did not have any other pertinent information to provide.

Participant #1 appeared eager to participate in the study and was actively asking questions about the study. He initially asked about which “hat” to wear throughout this interview as he holds various positions in the field of EMS, “...because I didn’t know if you wanted me to answer as me or answer as me the boss... because I wear so many hats...” I asked participant #1 to talk about his experiences as a paramedic and that he could also provide information on any other hats in which he may wear with the phenomenon being studied. Initially, I was aware of my personal feelings of anxiety regarding the first interview, but as the interview continued and it became informal, my feelings of anxiety reduced.

Prior to the start of the interview and after reviewing any minimal risks of participation, the informant spoke about the “curve” in EMS:

I mean there are honestly is a curve of those who are on the up side of the curve, EMS people are EMS people because we leave it there and we can totally separate ourselves from it. I mean that’s, it sounds cold, but honestly it is we treat and street and were done. And we move on to the next one. When you know when you’re on your up curve and that’s when the curve takes, everybody’s a different curve. Some people get over that in a year, two years, 5 years, 10 years... but once your on the down side, then now your on the mentorship role.

After discussing “the curve” in EMS and gaining a rapport with participant #1, I started the interview questions. I asked participant #1 to describe his experiences of responding to completed suicides in his role as a paramedic. He started his answer by discussing the experiences prior to arriving to the scene. “...you know, a lot of the times, mostly when the call comes in, you honestly don’t know what it is until you get there.” He talked about how most calls come in by a third party, “haven’t heard from them in a while or whatever,” “... it’s a third

party call”, “find them that way and a note or they’ve went over to check on them and they say they’re gone.” I prompted him to discuss what happens when he arrives on the scene, which he described “an order of events:”

...because at this point of time, we don’t know whether it’s a homicide, suicide, or whatever. So we have to make sure preservation of the scene is extremely important. We go in and our checks are enough just to make sure that the patient is deceased and cannot be revived and after that we back away until the police and the coroner get there. They secure the scene and make sure there’s not other weapons or whatever else it would be and potential dangers, and the coroner comes and do their investigations and pictures and what not. And then we get to remove the body.

Without any prompt, participant #1 talked about arriving on scene and how the scene varies at a completed suicide when family or loved ones are present. When loved ones are not present, “When your sitting by yourself... you know your reading Facebook, your listening to the radio, or whatever until somebody (coroner) gets there.” When loved ones are present, “families there, it makes it a little bit different because you keep them out.” He spoke about how police members have taken the role of “keeping family away and that type of stuff” as police officers are usually at a completed suicide scene. He tends to see family members less distraught on scene than at the hospital, “when I still have them and I’m working them, there’s hope. Once you get to the hospital and it’s over there’s no more hope.” Without further prompt, he started to talk about the impact of suicide calls and referred back to “the curve.” He spoke about how initially, responding to suicide calls was “anxiety provoking.”



You know it's not your compassion but your anticipation anxiety as opposed to, you know, you're after so many times, you know your job. So you just do it. It's not a, not cold, it's just reality of I've done this so many times. I know the routine.

Yeah, especially when it's your first time that you ever seen somebody hanging and the first time you've ever seen a note left and you've read the note, the first time it's ever been a young person and you know, their parents come. First time you've seen somebody with their head blown off... You know, it's the first time you've seen all of those it's... it's pretty wild. And then, again after the multiple times, and they all, they're very patternistic. You know, women are less traumatic they're less of the guns, although my last suicide was a lady who shot herself in the tub, last summer.

He then spoke about the pattern of suicides and how males are more likely to complete suicide by "more traumatic" methods, while females are less likely to use traumatic methods. He spoke about responding to suicide calls and how "you forget the bad times" and tend to "not dwell on them." In his 33 years in EMS he has only one "death" that he can recall which he "had regrets" or "what if's" which was a call of an unintentional drowning, as opposed to a suicide, "Yeah, the decision, whatever they've done, that decision was made long before, that decision had nothing to do with us. So you know I honestly don't get caught up in any it." "You're always asking what on earth. One of my dad's favorite saying is you know, 'This is a permanent solution to a temporary problem,' ...what could push you to that?"

We segued into a discussion about suicide attempts and how the experiences of attempts are much different than completed suicides. He spoke about experiences of arriving to the same person's house multiple times for attempted suicide and how this can be exhausting, "how much is drama verses how much of it is the real thing and is this an escalating thing and you know I've

picked up the same person 10 times for the same thing.” “The first time you know your believing it, and then after that it gets kind of less and less.” “You still treat the same but you know it’s just come on, here we go again.” As he continued to talk, he spoke about how you must “treat the same” as he has had individuals with multiple suicide attempt calls, but did later eventually die by suicide. Since the informant has worked primarily in a smaller town, he spoke about experiences in which he knew loved ones/family members of patients who have attempted suicide, “you keep the talking down to a minimum because there is no words. Those are more just a hug. It’s all you can do. Just a shoulder.” Prior to starting this interview, I wondered if any participants from smaller towns would describe having prior relationships with patients or their loved ones. I was pleased that he had addressed this in the interview without prompt.

While discussing small towns and having established relationships with family members of the deceased, he started to talk more in detail about the presence of loved ones of the deceased at the scene. He spoke of the importance of explaining the process and what would be happening, “a process that has to be done,” “it’s our job to explain that process of this is what we have to do first.” Family members often wish to see their loved ones and he spoke about the attempt to keep them away, which is primarily the role of police personnel. At this time his work cell phone rang and I waited until he was finished with his conversation to ask about any additional information he may have about the presence of loved ones at the scene. I took the opportunity to collect my thoughts and focus on what remaining questions I wanted to ask. Following his phone call, I prompted him again on his experiences of the presence of loved ones at the scene. He took a few seconds to reflect and then spoke about the procedure of suicide calls including a discussion about the coroner who must arrive to the house, the police personnel there to secure any weapons, the duties in which he has as a paramedic to collect all medications with the patients

name, and helping loved ones to make funeral arrangements. He spoke about the process of removing the body and transportation of the body:

“Please just hang out here let us go do our thing,” and as long as it’s not you know a decapitation or something like that then we try and let the family spend a little time you know with them. Once they’re on the gurney, cleaned up, laying you know laying in some type of, you know, never cover, we don’t cover their face up until were after our way out. Because, you don’t pull the drape, you know, um, and then we go either to the hospital to the morgue or to the funeral home.

After reviewing the transcript and audio recording, I realized that I didn’t have participant #1 reflect on the last question, as the subject had been changed. Rather, at this time I asked about any additional information, which without any prompt, he spoke about transportation of the individuals who attempt suicide to the hospital:

Yeah, there’s usually two avenues they go either one they are, their heads turned away and don’t want to talk or nothing. The other side of that is completely the opposite side. I mean, they’re either totally depressed or totally manic. And they never stop talking. You know, those are the ones that are usually just had a fight with a boyfriend or just had a fight with the girlfriend or just had a girlfriend with mom or dad. Those are usually young ones. The ones that scare me the most, this isn’t going to be the last time I see you... are the ones that totally withdraw and pull themselves away.

I wanted to find out more information about the impact in which responding to these type of calls has had on him so I asked that question and he responded, “It sounds real cold, but for me, nothing.” I encouraged him to go back to “the curve” which he responded:

I've never taken it home. I've never passed the next call. I've never lost sleep over it. Or anything. Again, I don't know if it's a cold thing, as much as it is a wall that we put up to be able to do our job further you know?

At this time I felt anxious about the lack of impact in which participant #1 had with the phenomenon at hand and questioned whether the focus of this study was significant. I reflected on this at the end of the study and later felt some sense of relief through responses in future interviews.

I finished up the interview with the last three questions that prompted participant #1 to talk about how he makes sense of his work as an EMS provider and how he maintains his work. First, I asked him to talk about how he makes sense of continued direct exposure to trauma as a paramedic which he took some time to respond, saying this question is "broad stroked," but after a few seconds of reflection, stated:

Trauma is, that's what, that's the adrenaline pusher right there. That's what gets us well you know, that's what gets us fired up. We're adrenaline junkies and you know trauma is it. That being said, all trauma is preventable. You know so, every bit of it is you know it's not like you didn't choose to have a heart attack, but you choose to get in that car. You know, but maybe you didn't choose to be in a wreck but never the less.

When I asked him to further describe how he makes sense of suicides he was quick to respond stating that he expected this question to be asked, "I don't make any sense of it, because my making sense of it that I have accepted the fact that it doesn't make sense" and further elaborated on how suicide is a preventable act and again stated his father's favorite quote: "It's a permanent solution to a temporary problem." Participant #1 said it's not his discipline to figure out why

individuals attempt suicide, “Yeah, I buy a clock, I didn’t buy the instructions on how to build the clock.”

While staying on the topic of responding to completed suicides, I then asked the question about how he makes sense of “witnessing” family and loved ones being present at the scene of completed suicides, which he began to quickly discuss the actual witness of one suicide in his experience where a man shot himself in front of him, “Shot himself in the railroad tracks, that was pretty wild” and elaborated on the initial shock “...did that just that happen?” He stated that this experience was “different,” because “since it was fresh, we worked it [CPR].”

He then began to talk about small town issues again, which we briefly discussed in the beginning of the interview. He described saving the lives of two individuals who attempted suicide via self-inflicted gunshot who he continued/s to see. He described having a prior relationship with one of the men who attempted suicide via self-inflicted gunshot and the other individual, which he would later see around town, “I have a good relation, I have a good, I have a fun relationship with them.” After reviewing the transcription, I had regretted that I didn’t explore this with participant #1.

The last question I asked participant #1 to reflect on was how he sustains his work as an emergency medical personnel. With some hesitation, he responded:

I eat, sleep, and breathe this. I honestly, this was my calling. And I, I am in intrigued with every facet of it from you know from the time I was 18, 16 when I started, til’ now, I don’t have any less enthusiasm now than I did before. I have a little better understanding than I did then. And now my role now as being boss and mentor now has changed to try and you know shepherd the ones that are and are not going to make it because I can tell.

As we were concluding the interview, I asked participant #1 if he had any additional information to share about his experiences, which he responded:

Hm, other than, I was excited about doing this. I didn't know where you were going to head with this. I didn't know if it was going to unlock things I hadn't thought of, but no, honestly this was fun."

I asked if it had "unlocked" any memories, which he described recalling some past events that he had not thought of for quite some time. I concluded the interview by thanking him for his time and reminded him that I would be sending him a copy of the transcribed interview for his review for accuracy, which he acknowledged and agreed to review. We walked out of the room together and I went to my car and took a few minutes to gather my thoughts. At this time I wrote down a couple ideas on the field notes about any other ideas that occurred to me and later took analytic notes about any ideas that I had after allowing myself to process the interview. Initially I was feeling concerned about the results of this interview, as I didn't hear that participant #1 has been impacted by calls of suicides, although "the curve" he described has varied throughout the years. As I gathered my thoughts, I reassured myself that the data collected in this study may vary and that any information shouldn't be expected, which helped to ease these nervous feelings. I planned to use the ideas that arose throughout the interview (e.g. probing EMS personnel in small towns to talk about their experiences with known individuals or later seeing individuals around town who have attempted suicide) with future interviews. I was happy that I was able to remain engaged in the interview and focused little on note taking or the structure of the interview.

The above narrative provides a review of participant's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance.

The interview with participant #1 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 2. Participant #1 Supporting Statements**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>I wear so many hats</i>  <i>Trauma is, that's what, that's the adrenaline pusher right there, that's what gets us well you know, that's what gets us fired up</i>
Lived space	<i>When you're sitting by yourself, you know, you're reading Facebook, you're listening to the radio, or whatever until somebody [coroner] gets there</i>
Lived time	<i>Some people get over that in a year, two years, 5 years, 10 years...</i>  <i>The ones that scare me the most, this isn't going to be the last time I see you, are the ones that totally withdraw and pull themselves away</i>  <i>When I still have them and I'm working them, there's hope</i>  <i>It's a permanent solution to a temporary problem</i>  <i>I have a little better understanding than I did then</i>
Lived relationship	<i>You keep the talking down to a minimum because there is no words. Those are more just a hug, it's all you can do, just a shoulder [knowing loved ones of the deceased]</i>  <i>I have a good relationship... I have a fun relationship with them</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>n/a</i>
Why?	<i>You're always asking what on earth?</i>
Negative emotions/burnout	<i>Anxiety provoking</i>  <i>...all trauma is preventable</i>
Support services	<i>n/a</i>
Shock factor	<i>You know, it's the first time you've seen all of those it's, it's pretty wild</i>  <i>...especially when it's your first time that you ever seen</i>

	<p><i>somebody hanging and the first time you've ever seen a note left and you've read the note, the first time it's ever been a young person and you know, their parents come. First time you've seen somebody with their head blown off. You know, it's the first time you've seen all of those it's, it's pretty wild</i></p> <p><i>...did that just happen?</i></p>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>...once you're on the down side [of "the curve"], then now you're on the mentorship role</i></p> <p><i>We're adrenaline junkies and you know trauma is it...</i></p> <p><i>I don't make any sense of it, because by making sense of it that I have accepted the fact that it doesn't make sense</i></p>
"I know the routine"	<p><i>...it's just reality of I've done this so many times. I know the routine</i></p> <p><i>...after so many times, you know your job</i></p> <p><i>...again after the multiple times, and they all, they're very patternistic</i></p>
"You have to let it go"	<p><i>I mean that's, it sounds cold, but honestly it is we treat and street and were done</i></p> <p><i>...not dwell on them [the bad times]</i></p> <p><i>You forget the bad times</i></p> <p><i>I've never lost sleep over it</i></p> <p><i>I've never taken it home</i></p>
Support	n/a
Detachment	<p><i>EMS people are EMS people because we leave it there and we can totally separate ourselves from it</i></p> <p><i>I don't know if it's a cold thing, as much as it is a wall that we put up to be able to do our job further, you know?</i></p> <p><i>It sounds real cold, but for me, nothing [emotional response]</i></p> <p><i>Yeah, the decision, whatever they've done, that decision was made long before, that decision had nothing to do with us. So you know I honestly don't get caught up in any of it</i></p>
Acceptance	n/a
Family become patients	n/a



Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCE</b>	
What I get from the work	<i>I am intrigued with every facet of it from you know from the time I was...16... when I started, til' now...</i>  <i>I don't have any less enthusiasm now than I did before</i>  <i>I eat, sleep, and breath this. I honestly, this was my calling</i>

**Individual interview #2.** The second interview was conducted with a 38-year-old, Caucasian, male, who identified as a paramedic. He has been in EMS for the past 20 years and has been a national registered paramedic for the past six years. He is currently working part-time as a paramedic in an ambulance agency and holds another full-time position as a paramedic within a larger company. In his demographic questionnaire, he has responded to an approximate 100 completed suicides. He responded “yes” to having personal experience with suicide, which he later discussed in the interview.

The interview was conducted in a conference room of a local university, which provided a quiet space for participant #2 to discuss his experiences. He arrived on time and I thanked him for participating in this study, which he stated he was more than happy to participate. Although he had been previously provided with the consent form, demographic questionnaire, and recruitment letter and flyer prior to the interview, I reviewed these documents with him. I made sure that he was aware that participation was voluntary and that he could leave the study at any time. He acknowledged voluntary participation and agreed to participate and signed the consent form. I informed him that I would be transcribing the interview and would email it to him for his review. I also reviewed the snowball sampling recruitment approach, which at this time he provided two names and phone numbers of participants that may be willing to participate. I informed him that I may be taking notes throughout the entirety of the interview. Following a review of this information, he completed the demographic questionnaire, and I began the

interview. The interview lasted one hour and two minutes in which at this time the participant stated that he had no further information to provide.

After reviewing the required documents, participant #2 began to talk about significant experiences as a paramedic while he completed the demographic questionnaire. He opened up about his experience while responding to a well-known natural disaster where he spent 17 days providing emergency medical services and responded to more than one “mass suicide.” It was apparent that he wanted to talk about this significant experience and he wanted me to know the impact this had on him, “The whole family, the dad left a note and he set his wife and kids and shot them all and shot himself. They were five days without electricity and well [they] don’t know how to function.” I validated how difficult this experience but have been for him. After this comment, he continued to complete the demographic questionnaire and was stumped when he got to the question that asked how many completed suicides he has responded to. I acknowledged the difficulty in recalling the amount of completed suicides and I asked that he provide an estimated amount. He described responding to over thousands of suicide attempts and over a hundred suicide completions. At this time he also made a comment about being a “poor paramedic” where he discussed the minimal pay in EMS and how he needed to find another full-time position in addition to his part time work.

After completing the demographic questionnaire and our brief discussion, I began the interview with the first question, which asked about his experiences of arriving to completed suicide calls. Initially, he spoke about often being first on the scene, prior to the arrival of police personnel or other first responders. He spoke about “trauma” scenes as “mass chaos,” but described the scene of a completed suicide as “... a sense of calmness,”

It's normally you go on a trauma call it's mass chaos, confusion when you arrive and you need to kind of calm the scene. A lot of times when you arrive on a suicide, there's a sense of calmness, like everybody's kind of... everybody's in shock I think. The loved ones, the family, the bystander, the neighbor, the police officer that shows up, they're just kind of in shock. And you just kind of take it all in.

I wanted to find out more about the emotional impact that this has on him and probed him to talk about the effects, which he answered:

I don't know if distant is the right word, I would say cold. It doesn't phase me anymore. Twenty years ago, it's like oh my god, but after you've seen so many of them. You see what society is, I mean 20 years ago, I was 18 years old and I was, I wanted to save everybody on the planet you know what I mean, but 20 years later, it's... you accept it.

As noted with participant #1, I sensed that time has provided an opportunity for participant #2 to distance himself from his work as a paramedic. He spoke about setting boundaries for himself emotionally, "...if you let every one of them bug you, you're going to be in this job a year and you will be done. Burnout." He describes leaving work at work, otherwise taking his emotions would "...tear apart my family, I wouldn't have a family and be divorced and living alone, probably be an alcoholic or something," which he describes seeing among many of his peers. I asked how this impact has changed over the years, which he began to open up about the loss of a loved one by suicide, "when my stepmom committed suicide, is when I kind of just like... okay this is where I build a wall and from here on they don't bother me, because that one shook home pretty hard," and he described experiencing "the other side" of being a family member/loved one. I felt shocked about hearing of the loss of his stepmother to suicide and felt the need to offer my condolences. He appeared comfortable talking about this and without prompt began to

openly discuss his loss. He spoke about how this loss changed his approach to responding to suicide calls and how his peers will often encourage him to respond to the suicide calls due to having personal experience.

Because I mean, I don't know if I connect better with the family because, you kind of have to be a grief counselor first with the family, explain what's going on, explain what you have to do. Because the family wants to know, why aren't you putting them in the ambulance? Why aren't you taking off? Why aren't you helping them? I mean, when there's obvious signs, there's nothing you can, you have to leave them there, until the police get there and the coroner get there. So you kind of have to separate yourself from the scene. Take care of the family. And I've been through that part. I was that guy. You know.

I reflected on his response about being "that guy," a family member who has lost a loved one to suicide, and how his work as a paramedic has changed from this experience. At this time he transitioned into a discussion about the presence of loved ones at the scene. Initially, he responded with a discussion about arriving to specific suicide calls that he could recall. One call particularly he stated "...a lot of suicides we respond to, it's been days. I mean I had one not that long ago, but it was a week," "...you could smell it out in the street." Another individual "shot herself in her moms driveway." At this time he seemed perplexed and wondered why anyone would do such an act where a loved one could find them. At this time, I probed him to talk more about his role when loved ones are present and his role as the "grief counselor" which he previously stated.

It's... it's something they don't teach you in paramedic school or EMT school. You just pick that up along the way. And then I think I was lucky enough when my stepmom

committed suicide, the paramedics there were some of my teachers, so it was kind of like we had a connection ahead of time. So they taught me how to deal with it. And I just kind of use those tools.

He began to speak about how often times the loved ones will then become the patients, where some may need to be placed in the ambulance and taken to the hospital and medicated. I had not given this phenomenon any prior thought and we spent time discussing the change of patient. He spoke about the focus on the loved ones, because with the deceased there is not much to be done “...you can’t do anything, but to wait until the coroner arrives “...if it’s a suicide or suspect anything, you don’t touch anything.” “If you aren’t transporting loved ones to the hospital themselves, it’s a process of waiting, “ “...you’re trying to control them, you’re trying to console them.” At this time, I thought about how long the wait must feel like to be with loved ones who must be going through one of the worst times of their life and how this role must feel different than providing routine emergency medical services.

We segued into a discussion about the change of environment when arriving to suicide attempts, which he had previously reported that he has responded to over a thousand of these calls. He described the environment as much different, “It’s a rush, it’s an adrenaline rush.” He began to speak about two different self-inflicted gunshot wounds that he arrived to in which both individuals had survived. The first he spoke about was of a teenager:

His dad said “Hey I’m going to \*\*\*\*\* [convenient store] to get a coffee do you want anything?” and he said “No, that’s ok, I’ll be here.” They live a half a mile from \*\*\*\*\* [convenient store]. His dad went and got coffee and come back and he’s on the floor with... he had taken a selfie with himself with a gun and was sending it to his girlfriend. Telling her that he couldn’t take it anymore or whatever.

He spoke about the police officers arriving first and the chaotic scene when he arrived, “I know the cops out there and they’re freaking out and they all know me, we’re like oh shit, we got to do something,” “it’s wild, mass confusion, chaos.” Participant #2 painted a picture of the scene and I sensed some anxiety from him as he spoke about the chaotic scene of attempting to save the life of a young adolescent. The other experience he spoke about was also a self-inflicted gunshot of a male who also attempted suicide following an altercation with his girlfriend. He then spoke about arriving to “attempted hangings” and the pattern of suicide attempts following altercations or break-ups with significant others and the increased risks of mood-altering substances, “Sober people who aren’t fighting with anybody I don’t think try to kill themselves.” I recalled that participant #1 had also mentioned arriving to attempted or completed suicides of individuals who had recent altercations with significant others. I wondered if this was a theme or pattern that many paramedics or EMT’s tend to see.

He spoke about the increased responsibilities as a paramedic, as opposed to an EMT, which of the 20 years in EMS, he has been a paramedic for 6 years, “I’m responsible now for all of A, B, and C when I get there, not thinking about your emotions to it, it’s thinking of this is what I have to do, this is what I’m going to do,” “...you’re the decision maker... you’re calling the shots.” He further discussed the support he receives in a small town and how EMS personnel and the hospital tend to work together, as opposed to larger cities. “...where as down here, you can lean on one another.” Having this connection in smaller towns appeared to be beneficial for participant #2.

At this point in the interview, I became aware that we had jumped from multiple topics, and I was concerned that I was jumping around topics too much. However, I continued to let the interview flow as it had been. Without any prompt, participant #2 began to open up about his

preference of medical calls as opposed to any type of trauma call, “When I was an EMT, I was all about the blood, bones, and gore. I wanted to see it all. But now it’s like, I’d rather fix people and make them feel better.” “It’s those success stories that make you appreciate the medical stuff.” He started to talk about the reward he receives when he helps to save a life from a medical call, “...those are rewarding as all get out... I don’t mean to brag but it’s rewarding you want what I mean?” He segued into a discussion of seeing individuals whom he’s helped save, later walking around town and the reward he receives from seeing them. This lead into a discussion about seeing individuals around town whom he has also helped to save following suicides, but that his reaction is much different with these types of survivors. I was happy that he started to talk about this, as participant #1 had also spoke of the small town phenomenon, “he waves and says hi you know... his dad is very thankful [the father of the adolescent who attempted suicide] and.... but it’s kind of like, why would you shoot yourself? You just want to grab him and why?”

What happened? What was so wrong at that point in your life that you had to do it? I mean I’ve been broke, I’ve been dumped, I’ve been divorced. I have a kid that I don’t hardly get to see, but I’ve never one time in my life thought about, you know what, this is it.

He further elaborated:

It’s wild, like, I run into that kid and his family at Walmart and like you can tell that, like his head’s misshapen and he’s missing an eye, but, so you know are people like what happened to this kid? Does he tell people? That’s what I want to ask him.

He started to speak of his stepmother and another female he knew that had completed suicide and had “battled” mental health concerns and addiction, “...how many people are out there walking that line every day... and could be like, today’s the day.” I prompted him to talk about what the

experience is like when responding to a suicide completion call where you knew the individual. “You wonder why, first question, what, I wouldn’t say the first question, but eventually you’re like, why? What happened? Like, what happened behind the scenes that nobody knows about. What caused it?” He started to talk about suicide attempts again and spoke about feeling “angry” and stated, “You get mad at them” when they have attempted suicide multiple times and have been “unsuccessful,” “if you really, really were committed, you wouldn’t have called anybody.” He described a difference in emotions with responding to “true [suicide] attempts” as opposed to an individual taking medication and then calling 9-1-1:

I don’t want to say that I feel sorry for those people. Something went wrong. You know, I feel bad that you’re at this point in your life where you think this is the only answer. You know, I feel bad for people, but I’m not in a position to hang out with you. I mean, were not going to be best friends.

Rather than connecting emotionally with patients, he talked about the role of arriving to the home, treating them, and taking them to the hospital, “Move on to the next one... we call it the twenty minute rule. I am with you for twenty minutes. I am going to impact your life for twenty minutes and I may never see you again.” I sensed that he has established boundaries within his work as a paramedic and distanced himself from having an emotional impact from most calls.

At this time I asked if there was anything else he wanted to add about experiences of loved ones at the scene before moving on to the next topic, which he stated, “I worry about the family members doing it themselves” and that he doesn’t like to leave people alone following the suicide of a loved one and will often call in family members, a friend, neighbor, or a priest. He states after time, you tend to “forget” about those emotions, “I mean it’s a horrible thing to say, but, you have so much going on. I am worrying about the next call, by the time I’m 4 calls down



the road, I've already forgotten about this guy.” He also spoke about concern for new EMS personnel partners, “because like, if this is his first time, you’ve seen human brain hanging out of a head” and will often allow his partner to separate from the scene if he notices any emotional reaction from them and spend time debriefing with them. I sensed that he felt responsible for the emotions of EMS personnel who are new to the field and a desire to ensure that their emotional well-being is okay.

This lead into a discussion about debriefing which he reflected on organized debriefing, “I thought it did more harm than good.... because they wanted to force you to talk about it and if I don’t know you I’m not opening up to you.” He described a desire to communicate with his peers, “yeah someone who can get you, who’s been there, knows what we go through.” “It’s a closed knit group you know, we don’t let outsiders in.” I informed him that a lot of the research I reviewed also provided similar responses. He further expressed the “dark sense of humor” that EMS personnel have. This prompted him to discuss a specific call of a self-inflicted gunshot wound:

This kid’s eyeball is hanging out, it’s when we picked him up, there was brain matter, I had it all over my shirt...but when his eyeball kind of like rolled and hit my arm, I’m like focus, focus, focus.

At this time, I pictured this image in my head and I wondered what qualities emergency medical personnel must have to maintain and self-care through continued trauma exposure. He spoke about a sense of humor following this experience, “when we were talking about it later that day, \*\*\*\*’s like, do you think he could see anything out of the eye ball?”

He then spoke about debriefing when he had responded to a natural disaster and went on to talk about his experience with “mass suicides” at the disaster sites “...how in the world could I

sit my kid on the couch one on each side of my wife, and shoot all three of them and turn the gun on... I couldn't do it." I noticed his face looked confused and the tone in his voice sounded disgusted, "We had more than one beer drinking debriefing after that trip."

Following a discussion of debriefing, I began to ask about how he continues to do trauma work? He responded:

Somebody's got to do it. And it's all I've ever done. I mean, 18 years old, it's all I've known. I grew up in the fire services. My dad was an assistant chief for 22 years. I think I might have been conceived in the fire station. I mean... my brother and I are... he's as active as I am. It's all I've ever done.

I further asked if EMS was part of his identity when he responded "yeah, absolutely." We segued this discussion into how he continues responding to calls where loved ones and family members were present, which he then stated,

So, I mean I've been in their shoes. I can, I don't know, I think I can handle it better for them. ... as opposed to one of the paramedics who's working with me. Because they've never been through it. So I know like, I am a rough, grough, mean SOB 90% of the time. There's no doubt about it. I complain a lot, I whine, I'm mean. But, when it's game time... my wife looks at me sometimes and she will be on across the street and say why are you so compassionate with those people? You don't even know them.

He further stated "These people are having the worst minute of their life, ever, I don't need to make it worse, I'm there to make things better," "...they need somebody to help them along... you put them first." It appeared that he has an empathetic personality when it comes to his work in EMS. He spoke about the opportunity for the family to see their loved one for one last time after explaining to them the procedure in which must be done by the coroner, etc. This triggered

a memory for him about an elderly man who had hung himself and his wife “freaked out” because he covered the deceased’s head with a sheet during transportation of the body to the ambulance. He spoke about how he never previously considered the impact that covering the face of a loved one had on family members prior to this event. We spoke about how his experiences have really shaped the paramedic that he is today.

Even though we had covered a lot about how he sustains his work as a paramedic, I asked about any last additional information he may want to add to that question. He responded “...I’m good at it...” and further stated:

In the hometown, the small town I’m in, everybody in the community knows me. I mean, my trucks got a light bar on it, they all know I’m the captain of the fire department. I’m the community paramedic. When I show to somebody’s house and they’re having a horrible moment, you can see the sense of relief over their face when I come to the door. I mean it’s just... it’s nice because I’ve grown up there. I know everybody. Those people knew my parents before I was alive. So...

We concluded the interview after participant #2 expressed that he had no further information to provide. At this time we both walked out of the room and I thanked him for his time and discussion of his experiences and reminded him that I would be sending him a copy of the transcribed interview. I went home and immediately took additional notes about thoughts that occurred to me throughout the interview. I was happy with the results that I received throughout this interview. What seemed so significant in this interview was the personal loss of suicide and the impact it has had on him in his work in EMS. I felt more confident in this interview than the first interview, as the structure of the interview was starting to become natural.

The above narrative provides a review of participant #2's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #2 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 3. Participant #2 Supporting Statements**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<p><i>...you just kind of take it all in</i></p> <p><i>...you could smell it out in the street</i></p> <p><i>It's a rush, it's an adrenaline rush</i></p> <p><i>This kid's eyeball is hanging out, it's when we picked him up, there was brain matter, I had it all over my shirt, but when his eyeball kind of like rolled and hit my arm, I'm like focus, focus, focus</i></p>
Lived space	<p><i>Mass chaos [suicide attempts]</i></p> <p><i>There's a sense of calmness [completed suicide]</i></p> <p><i>...we're like oh shit, we got to do something [at the scene]</i></p> <p><i>...it's wild, mass confusion, chaos [suicide attempts]</i></p> <p><i>These people are having the worse minute of their life, ever, I don't need to make it worse, I'm there to make things better</i></p>
Lived time	<i>...you can't do anything... but to wait until the coroner arrives</i>
Lived relationship	<p><i>...I'm not in a position to hang out with you [following care to an individual who attempted suicide]</i></p> <p><i>...they need somebody to help them along... you put them first</i></p>
<b>2. RISK FACTORS</b>	
Taking it home	<i>I wouldn't have a family and be divorced and living alone, probably be an alcoholic or something</i>
Why?	<p><i>...but eventually you're like, why? What happened? Like, what happened behind the scenes that nobody knows about? What caused it?</i></p> <p><i>...why would you shoot yourself? You just want to grab him and why?</i></p>
Negative emotions/Burnout	<i>You get mad at them [individuals with multiple suicide attempts]</i>

	<p><i>...angry</i></p> <p><i>I don't want to say that I feel sorry for these people, something went wrong. You know, I feel bad that you're at this point in your life where you think this is the only answer. You know, I feel bad for people</i></p> <p><i>I worry about the family members doing it themselves</i></p> <p><i>...if you let every one of them bug you, you're going to be in this job a year and you will be done. Burnout.</i></p>
Support services	<p><i>I thought it did more harm than good...because they wanted to force you to talk about it and if I don't know you I'm not opening up to you [professional debriefing]</i></p>
Shock factor	<p><i>A lot of times when you arrive on a suicide, there's a sense of calmness, like everybody's kind of... everybody's in shock I think</i></p> <p><i>The loved ones, the family, the bystander, the neighbor, the police officer that shows up, they're just kind of in shock. And you just kind of take it all in</i></p> <p><i>...because like, if this is his first time, you've seen human brain hanging out of a head</i></p>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>I think I can handle it better for them...as opposed to one of the paramedics who's working with me. Because they've never been through it</i></p> <p><i>I've been in their shoes</i></p> <p><i>Dark sense of humor</i></p> <p><i>The other side [being the loved one of a deceased patient to suicide]</i></p> <p><i>When I was an EMT, I was all about the blood, bones, and gore. I wanted to see it all. But now it's like, I'd rather fix people and make them feel better.</i></p>
"I know the routine"	<p><i>...twenty years ago, it's like oh my god, but after you've seen so many of them...</i></p>
"You have to let it go"	<p><i>Move on to the next one</i></p> <p><i>I mean it's a horrible thing to say, but, you have so much going on, I am worrying about the next call, by the time I'm four calls down the road, I've already forgotten about this guy</i></p>

Support	<p><i>...they taught me how to deal with it</i></p> <p><i>...yeah someone who can get you, who's been there, knows what we go through</i></p> <p><i>...where as down here, you can lean on one another</i></p> <p><i>It's a closed knit group you know, we don't let outsiders in</i></p> <p><i>We had more than one beer drinking debriefing after that trip</i></p>
Detachment	<p><i>...not thinking about your emotions to it</i></p> <p><i>...when my stepmom committed suicide, is when I kind of just like... okay this is where I build a wall and from here on they don't bother me, because that one shook home pretty hard</i></p> <p><i>I don't know if distant is the right word, I would say cold</i></p> <p><i>So you kind of have to separate yourself...</i></p>
Acceptance	<i>You see what society is, I mean 20 years ago, I was 18 years old and I was, I wanted to save everybody on the planet you know what I mean, but 20 years later, it's... you accept it</i>
Family become patients	<p><i>...it's something they don't teach you in paramedic school or EMT school, you just pick that up along the way [providing care to loved ones]</i></p> <p><i>Grief counselor</i></p> <p><i>...you're trying to console them</i></p>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<p><i>When I show to somebody's house and their having a horrible moment, you can see the sense of relief over their face when I come to the door. I mean it's just... it's nice because I've grown up there. I know everybody.</i></p> <p><i>"...those are rewarding as all get out... I don't mean to brag but it's rewarding you want what I mean [medical calls verse trauma calls]</i></p> <p><i>I'm good at it</i></p> <p><i>My dad was an assistant chief for 22 years. I think I might have been conceived in the fire station. I mean... my brother and I are... he's as active as I am. It's all I've ever done</i></p>

**Individual interview #3.** The third interview was conducted with a 38-year-old Caucasian male who has been in EMS for the past 20 years. He identified as a nationally registered EMT, an assistant fire chief, and fire service and EMS instructor. On the demographic questionnaire he noted that he has responded to 15 completed suicide calls in his role as a paramedic and he did respond “yes” to having personal loss to suicide. The interview was conducted at his place of employment in a private office. Initially when I arrived to the office he was out on a call and I sat and waited for him while a couple other employees were also present. I made small talk with them until participant #3 arrived. He arrived about 20 minutes later and we started the interview. Prior to our meeting he had been provided the consent form, demographic questionnaire, a recruitment letter and flyer, and we reviewed these documents again prior to our interview. I emphasized voluntary participation in this study, which he acknowledged and he agreed to participate. I informed him that I would be emailing him a copy of the transcribed interview for him to review, which he agreed. I reviewed the snowball-sampling recruitment approach with him to obtain additional participants, which he acknowledged and provided three names and phone numbers of EMS personnel. I also informed him that I may be taking notes throughout the interview. He voiced an understanding of the requirements asked of him and his signature was obtained on the consent form. He completed the demographic questionnaire and I began the interview. The interview lasted about 58 minutes at which the participant expressed that he had no further information to provide.

As we finished up the review of the above documents, he asked if he could step away for a minute to talk to the other EMS personnel in the station, as he had been “in charge” since the assistant chief had been away. I emphasized that we could stop the study at any time if he needed for his work-related duties. After he came back, we started the interview. The first question I

asked participant #3 was to describe his experiences with responding to completed suicide calls. He immediately started talking about the presence of family at the scene, which made me think that he had reviewed the documents and saw that this was the essence of the study. He stated, “The one without family there is actually the easiest” and “the easier route.” He spoke about a calmer scene without the presence of loved ones, “...nobody is frantic, um, family always adds something to it, that we don’t like to see,” “...it’s almost like they don’t grasp it on the phone, you, you can’t get through to them, they actually have to come see it.” When loved ones are present, he explains “It’s always the hard when the loved ones find them.... they’ll be the ones to find them. And they don’t leave a note or anything it seems in all the experiences I’ve had...” He describes what is most difficult for him is when he thinks back on suicide calls in EMS and fire service; nothing would “drive you to that point.” Further, ... “it’s not the fact that your judging them, ‘cause your not. But your trying to figure out what was they going through in their mind to actually, actually get them to that point.” He spoke about the fact that you may never know the reasons why somebody decided to kill themselves, “...and trust me, you think about it.” I noticed a calm tone to participant #3’s voice so far in the interview, he appeared empathetic and this demeanor continued throughout the remainder of the interview.

At this time, I prompted him to talk about the impact that responding to suicide completions has had on him:

Pretty much you try not to think about it. Um, hopefully that call is backed up with another one real quick. So you can get your mind off of it. If not, you go back to the station and you talk about it with your partner. You do whatever you have to do to get your mind off of it. We do the same thing here at the fire service.



This comment segued into a discussion about debriefing and how he tends to engage in peer debriefing following most calls. He spoke about a supportive environment in EMS and fire services, “I mean, you trust somebody when you go out on the truck in any setting with your life, so you have to trust them when you get back to the station too.” I prompted him to talk about the impact again, as it appeared he had more that he would like to say:

I guess I’ve never really thought about it that much. But, it makes ya, it makes ya sit back and value life more. Just like I told you before, you wonder what the person was thinking. You’re not judging them when you wonder, but you’re just wondering why do they do that? What was bring a person to do that and makes you value your life. You can sit there and say that no I would never do that. Well you honestly don’t know what that persons going through in their personal life. I can sit here and say that nothing would ever drive me to wanting to kill myself, but I’ve never been pushed that far.

He further stated, “it actually changed me... I used to go out and judge patients, I don’t do that anymore,”

Yeah. Through the years you, you see nobody calls you because they’re having a good day. They call you when they’re having the worst of days. They expect somebody to show up and take care of that. And it just makes you value it just a little bit more that you’re the one that can go take care of that for them or treat them with decency after they do what they need to do. You know?

He continued to discuss the empathy he has toward his patients and his attempt to understand what patients and loved ones are experiencing, “They’re in no way any better than anybody else.” We started to explore his role when family members are present, while he explained that the police and a coroner must arrive before they can transport the body. He

describes his role as keeping loved ones away from the body as often loved ones and the first responders at the scene can't make sense of the actions that have taken place "...there's a lot of unanswered questions that you know, hit you personally and business wise when you go home and call it a night."

At this time, participant #3 started to talk about his personal experience of losing a loved one to suicide. He stated that about three years ago his brother had shot himself in the chest and still to this day there are no answers or making sense of it. I offered my condolences to him regarding his personal loss, which he responded "...that's why I won't judge anybody else because it's somebody's family member." He talked about how going through this personal loss changed him as an EMS personnel, "...it gives a whole new meaning to it." We continued to discuss the impact that personal loss to suicide has had on him and how it has changed his work in EMS.

I segued the conversation into a discussion about suicide attempts and his experiences of arriving to suicide attempt calls. He spoke about how many calls are non-threatening, rather these individuals tend to be going through difficult times and just want somebody to talk to, which he states he provides a listening ear for them. "...I don't know how many people that I might have talked out of doing it, sometimes you can without even talking, they want somebody to listen to them." "...the ones that actually do it are the ones that want to do it. The ones that don't are the ones that are looking for somebody to talk to." I sensed that he finds it meaningful to listen to loved ones of the deceased and ensure that they have the support they need before leaving the scene. I felt we were coming to an end of discussion about his experiences with suicide calls and attempts and asked if he had further information, which he started to open up about the emotional impact it's had on him.

Well if I sit here and told you that I didn't have nightmares about some of the stuff, I would be lying. You do. ...some of the things and what people can do to themselves, is something that you'll never, ever, forget. I mean...it... they talk about um... they talk about military people and I give them all the credit in the world. PTSD and stuff. We get to it too. You know were just not recognized for it, but were supposed to be able to handle it. 'Cause that's what were called for, but we get it just the same, I mean, lots of times there's sleepless nights. You might be remembering something that you know, that you've seen or death that you've encountered.

I sensed that he felt EMS personal are encouraged to hide their emotions and to disconnect emotions from their work, which he described can be difficult at times. He spoke about the "brotherhood" as "the best support system in the world" in fire service and EMS and how this support system has been most beneficial in his work, as opposed to talking about his experiences with his family "...they don't really need to know that." He described an attempt to leave work issues at work, but due to the supervisory position he is in, it tends to follow him home.

I stopped to summarize all information we had discussed at this time and asked if he had any additional information to provide on the topics we discussed thus far. He started to open up more about our discussion of family and loved ones being present at the scene. Like the last interview, he spoke of loved ones at the scene often becoming patients due to their emotional response from the loss of a loved one.

We've had that happen before. It happens more times than what you think. You know... grandma falls down with chest pain or shortness of breath or something... will you take her down to the hospital and you call another unit to cover that. So that's why... that's why you know our role is toward the family when the family is there. Now we don't just

leave the patient go you know... the one that killed themselves. But our role is taking care of the family members...

I prompted him to talk about the secondary trauma exposure and attempted to provide him with a brief definition of what this meant. As I spoke, I felt I was not making much sense, which he validated by asking what I was trying to ask of him. At this time I was a little concerned about my ability to provide a clear definition of vicarious or secondary traumatization and attempted to explain it in a simpler way. He grasped the idea and responded with a response about how difficult it is, "...but you can't help but feel sorry for people, if you don't feel sorry for people and want to help them, you're in the wrong profession." He opened up more about his personal loss to suicide and what he feels for family members because he knows the road ahead for them, "trust me from personal experience, that [lack of closure] don't end."

Right before I asked participant #3 to talk about how he sustains his work as an EMS personnel, he started talking about the "rewarding" calls and all of the trauma calls where he saved lives, "it's no greater feeling than cut somebody out of a car and known that you just saved them.... I can remember in 20 years, almost every call like that, that I've been on." He expressed how easy it is to recall the rewarding calls, but how difficult it is to recall scenes which we have talked about in this interview. I followed up with the question about how he sustains his work as an EMT, which I assumed that he would continue his discussion of the reward in which he receives. He spoke about how every call he has is different and that's what keeps him going. At this time his phone rang and he took a few minutes to talk to an employee. After he concluded his phone call, I ensured him that we had just a couple more questions for him, which he was agreeable to answering.

One of the last questions was about his work with trauma in general and how he makes sense of those calls, which he talked about how trauma calls are the “easiest calls” to have because they are “cut and dry.” I further asked him to discuss how he makes sense of loved ones presence at any type of scene. He talked about how the presence of loved ones is much different at an “actual trauma,” and how much easier it is to talk to family because the trauma is usually an accident, as opposed to suicides. “We all cringe at the thought of having to go on a suicide.”

At this time I asked if he had any additional information that he wanted to add which he declined. We concluded the interview and I thanked him for his time and discussion about his experiences. As I got into my car, I reflected on the interview. I noticed the demeanor in which participant #3 had as opposed to the last two interviews. He was calm in his tone, empathetic when discussing patients and their loved ones, despite being in the field for 20 years. I was happy with how the interview went. What was most significant in this interview was the personal experience to suicide and how it has helped to change his ways of providing emergency services. When I got home I used my field and analytic notes to write about any thoughts that occurred to me following the interview.

The above narrative provides a review of participant #3’s descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #3 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 4. Participant #3 Supporting Statements**

Analytical Categories	Supporting Statements
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>We all cringe at the thought of having to go on a suicide</i>
Lived space	<i>...it's almost like they don't grasp it on the phone, you, you can't get through to them, they actually have to come see it</i>

Lived time	n/a
Lived relationship	<p><i>...family always add something to it that we don't like to see</i></p> <p><i>And it just makes you value it just a little bit more that you're the one that can go take care of that for them or treat them with decency after they do what they need to do</i></p> <p><i>...that's why I won't judge anybody else because it's somebody's family member</i></p> <p><i>...I don't know how many people that I might have talked out of doing it, sometimes you can without even thinking, they want somebody to listen to them</i></p> <p><i>...but you can't help but feel sorry for people, if you don't feel worry for people and want to help them, you're in the wrong profession</i></p>
<b>2. RISK FACTORS</b>	
Taking it home	<p><i>...trust me, you think about it</i></p> <p><i>Lots of times there's sleepless nights. You might be remembering something that you know, that you've seen or death that you've encountered.</i></p> <p><i>Trust me from personal experience, that [lack of closure] don't end</i></p> <p><i>...hit you personally and business wise when you go home and call it a night</i></p> <p><i>they talk about military people and I give them all the credit in the world, PTSD and stuff. We get it too</i></p> <p><i>...some of the things and what people can do to themselves, is something that you'll never, ever forget</i></p> <p><i>...if I sit here and told you that I didn't have nightmares about some of the stuff, I would be lying</i></p>
Why?	<p><i>I can sit here and say that nothing would ever drive me to wanting to kill myself, but I've never been pushed that far</i></p> <p><i>You're not judging them when you wonder, but you're just wondering why do they do that</i></p> <p><i>...it's not the fact that you're judging them, 'cause you're not. But you're trying to figure out what was they going through in their mind to actually, actually get them to that point</i></p> <p><i>...there's a lot of unanswered questions...</i></p>
Negative emotions/burnout	n/a

Support services	<i>n/a</i>
Shock factor	<i>n/a</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<i>...it actually changed me [personal loss to suicide] ... I used to go out and judge patients, I don't do that anymore</i>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<i>...hopefully that call is backed up with another one real quick. So you can get your mind off of it</i>  <i>Pretty much you try not to think about it</i>
Support	<i>If not, you go back to the station and you talk about it with your partner. You do whatever you have to do get your mind off of it...</i>  <i>...you trust somebody when you go out on the truck in any setting with your life, so you have to trust them when you get back to the station too.</i>  <i>Brotherhood... the best support system in the world</i>
Detachment	<i>n/a</i>
Acceptance	<i>n/a</i>
Family become patients	<i>grandma falls down with chest pain or shortness of breath or something... will is you take her down to the hospital and you call another unit to cover that. So that's why... that's why you know our role is toward the family when the family is there. Now we don't just leave the patient go you know... the one that killed themselves. But our role is taking care of the family members...</i>
Their misfortune made me realize my life was pretty precious	<i>...makes you value your life</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>...it gives a whole new meaning to it [regarding personal loss to suicide]</i>  <i>Rewarding</i>  <i>...it's no greater feeling than cut somebody out of a car and know that you just saved them.... I can remember in 20 years, almost every call like that, that I've been on</i>

**Individual interview #4.** The fourth interview was conducted with a 30-year-old Caucasian female who has been an EMT for the past eight years, with a certification as an EMT-B. In addition to her role as an EMT, she is also a full-time student and will soon graduate with a

bachelor's degree, with hopes of applying to a masters degree program in a medically related field. To secure anonymity, the school program she is enrolled in is not identified, but her goal is to work in the medical field within a different role and discontinue her work as an EMT.

The interview was conducted in a private room at her university library, which provided a quiet and confidential place for our meeting. She had been provided with the consent form, demographic questionnaire, and a recruitment letter and flyer prior to our meeting. We reviewed these documents again and I emphasized voluntary participation. As we spoke about the consent form and she saw "IRB" printed in the top corner of the form, she spoke about a research project that she is conducting for school and how she has also applied through IRB. I believe this helped to gain a rapport and a connection prior to the start of the interview. I informed participant #4 that I would be sending a copy of the transcribed interview for her to review. I also informed her that I may be taking notes throughout the interview process. She voiced an understanding, agreed to participate, and was agreeable to reviewing the transcription for accuracy. She noted that she has responded to an approximate 40-50 completed suicide calls on the demographic questionnaire and responded "no" to having any personal loss to suicide. The interview lasted about 48 minutes at which the participant expressed that she did not have any other information to provide.

Following a review of the documents and gaining participants signature on the consent form, we began discussing the county in which she works in. Although some of this information was discussed in prior interviews, I regretted that I didn't ask more information about the number of calls and the size of the counties in which the EMS personnel provided services to. Participant #4 works in a larger county and her ambulance company receives about 60,000 calls per year. She wanted to make sure that the information that we discussed was confidential and I reviewed



confidentiality and I asked that she not inform me of any patient identifying information, which she agreed.

After a discussion about the company she is employed with, I started the interview and I first asked participant #4 to describe her experiences in responding to completed suicide calls. She immediately spoke of the first suicide she responded to of a 17-year old male that had completed suicide by a self-inflicted gunshot wound, "...why it was so significant to me, is because he waited until his mom got home...and he just shot himself right in front of her." She described the mother's reaction, "it just imprinted on me so much because of how it was her initial reaction to it" since they arrived to the scene immediately after.

It was her initial reaction and I was standing out there when the father got home. And no one had said anything to him. And he just saw our ambulance and the um, police cars and um, his wife standing there and he just collapsed to the ground. And it was like slow motion to me almost.

She elaborated on this experience "...yeah, I remember just about every detail of it,"

She called right away, thought he might still be alive. She just didn't understand. We got in there, the room was still full of smoke from the gun. And um, he had shot himself in the head with, I don't know guns at all, but it had caused severe damage. And um, it was just her emotions was just so raw and just, there was nothing to do. That's one of those things where you're the responder and you want to know, what do I say to people? What do I do? And there's nothing to say or do. You're just...

She spoke of the father's initial reaction as he pulled up the driveway without any knowledge of the event:

I mean, I just remember, just was like every single one of us just turned and looked and it was like slow motion, I don't know how, but he was walking up the driveway and his face just fell, and he fell to the ground. He just knew. It was... we let the wife ran to him and they just held each other and cried for a while. And we had them in our truck and just stood around, not being able to help at all with anything.

At this time, I felt an emotional response from myself, as I listened to her talk about the loss of an adolescent to suicide. She had described the scene and the raw emotions experienced from the deceased's parents. I felt a sense of sadness within myself and how difficult this call must have been. I sensed that this call really impacted her.

I asked about the change in roles when arriving to this type of scene as opposed to other types of calls where the role is to provide emergency medical services.

That's the biggest, I think that's why I remember it so well. I always remember the mistakes that I make, that I need to go to a scene and I need to know what to do and I need to do it. And when, I think that was a problem. I went to the scene and I had no idea what to do. It was one of my first suicides that I handled and it was certainly the first with someone so young. And I just didn't know what to do and just stood by the mother, just in case someone could tell me what to do. You know.

As I listened to her response, it seemed as if she felt lost with what role or service to provide, as she later stated this was the first suicide call for her after being an EMT for about two to three years. On the demographic questionnaire she listed responding to about 40-50 suicides since then but how this initial suicide had the most impact on her due to his age and the lack of "psychological history" this individual had. Whereas, she describes most suicides she has responded to since have had some history of psychological problems and family members had

expressed fear that suicide would be the end result. She describes that she has learned her role or job following additional suicide calls, "...were going to call the coroner, were going to call to help make arrangements for what to do with your loved one." She further stated "And I think it's not as hard now, because of the fact that I did go through one early on...every case after the first one is a little bit easier I think."

At this time, I asked about any further impact that arriving to a suicide or traumatic calls have had on her.

Well, early on, um... I'd get home and I'd wonder you know if this was the right job for me. And how I can keep facing this. And then, after a while, there's this mantra and maybe you've heard it, and at first I hated it and I rejected it and I was so mad about it. But it says, "The worst thing that could possibly happen to that person has already happened." And I really accepted that.

She further elaborated:

Even as senseless as suicides can be and as senseless of you know overdoses and these car accidents that people get in because they're impatient. As senseless as they are you know it's completely out of my control. And I can't hold that on me.

It's not that... I've really tried to avoid the word burnout because it's a dirty word to me.

I am not burnout, I'm not emotionless, I still sympathize with patients and their families.

But um, I can't hold on it on me as my own fault or my own responsibility. So when I leave work, I leave work there and I don't take it home with me.

I asked her how she has learned to leave work at work, which she expressed how difficult this was initially, "...at first what everyone thought of me and all of that just was always weighing on me and it was really hard." She stated, "stop carrying those calls with me." She described having

coping mechanisms, which have helped her manage her emotions. She also spoke of going home and “writing it all down... I would get home and I would just type it all out, type the whole call out and I felt like I was just putting it away...” She also described how she has changed after meeting her husband, “Just knowing that even when I’m on a call, just knowing that he knows that I can do it, really makes a difference.” She further elaborated on improving her confidence level and having the support from her husband has helped her to further her education. She spoke how confidence is really important in EMS:

Just be able to walk up to a patient’s family and say I know what I need to do and like proving that you have that confidence so they can trust you to help their family member is a big, big part of it.

We segued our discussion into a discussion about the presence of loved ones and family at scenes where they are all looking at her in the moment, “...I know everyone is looking at us to have that yes or no [alive or deceased].” She spoke about the “adrenaline rush” and how she must “keep it together.” She stated “you kind of get these little blinders on to try not to take in everything all at once and just focus on your patient and then focus on the family if the patients gone.”

I’ve had family members standing over me screaming you know, right in my ear. Trying not to pay attention that I’m kneeling on trash and needles... you know, just focusing on the patient, doing what needs to be done, you know, every single time. But you know, after a while like I was saying earlier, running arrests (described by participant #4 as “the heart stopped functioning”) you get that rhythm of a call that you just know what your supposed to do, you just do it, and you think about it later.

She further stated "...just focus on your patient and then focus on the family if the patients gone," which reminded me of how prior interviews have mentioned the family members becoming patients themselves. She started to talk about the "latter" and how she can feel herself "coming off of that" which is what she states usually gets her through the call. I prompted her to talk about what she meant by "coming off of that," which she stated "...a little bit like waking up, you know, you can feel yourself calming down and feeling everything like slowing down a little bit better. 'Cause everything moves so fast on an arrest and stuff like that." I reflected back to her what she said and she responded:

...whatever's happened to them has already happened, it's senseless that they tried this whether it was completed or not. I don't emotionally like attach to it but I do get the adrenaline rush just to get my job done, but 9 times out of 10, even if you work it, you get to the hospital and they call it.

At this time she reflected on a call (an unintentional overdose) where the family members were at the hospital and accused the medics of killing the patient and how someone standing next to her told her, "you have a really hard job don't you?" She said that was a point in her career where she knew she didn't need to carry that with her. I reflected, "Hard job that you do?" and she responded "I love it."

We briefly spoke about coping mechanisms earlier in the interview and I prompted her again to talk about self-care as an EMT:

Self care then, I gained 40 pounds in two years, I didn't know what to do. I um, before I started working in EMS, I was 100% a completely different person. I never swore, I never drank, I was quite a bit skinnier and I started using coping mechanisms I saw my

coworkers doing. Where a lot of them eat too much, drink too much, and swear too much, and then I realized.

She reiterated how her husband helped her to see how that these mechanisms were unhealthy and that they weren't working for her. She spoke about how this job has changed her, "...mostly for the good." From our discussion thus far, I noticed that participant #4 described a difference in her emotional response over time. It appeared she has learned new and healthier coping mechanisms and has been empowered by her husband. While on the topic of self-care I asked about debriefing services that she has engaged in, which she described having only internal, peer support services, where at the end of the day they talk with each other and "letting off the steam." She has declined professional debriefing services, but states that they are offered if needed.

Before moving on to the next question, I asked if there was any additional information that she wanted to add, which she stated "...testing myself to know the limits of my strength has kind of given me that confidence that I have now at the end of it." She spoke about the difficulty with not ever knowing the outcome of patients, "...especially with family members, not to hear their response or their gratitude..." We discussed the difficulty of this and lack of closure on patient outcomes. At this time I asked her if she has known any patients she has responded to while working in a larger county, which she responded that her husband encouraged them to move out of the city in which she worked as she would often drive by houses, "...I've been in that house, I've been in that house..."

I asked a general question about how participant #4 makes sense of her continued exposure to traumatic events, "Um, time and chance happen to us all. There's no sense to it... it's just split seconds change your lives. In one way or the other." She further explained that she

can't make sense of it like she initially tried, "...a lot of it's senseless." I further prompted her to talk about how she makes sense to responding to suicides and the presence of loved ones at scenes. She described an attempt to understand what they were going through by communicating with family members and further stated, "...I can't blame anyone for it you know, but I feel like there are definitely reasons for those kinds of things." She described the reward that her job provides her when family and loved ones are at scenes, "...just being able to go in and say I know what to do and taking that weight off the family members, I love that about my job."

The last question I asked participant #4 was how she sustains her work as an EMT. She responded, "Yeah. I do absolutely love my job and I was really lucky enough to find something I'm very passionate about. Um, I think it gives me as much as I give it. So that really helps me go everyday." She described a change in careers eight years ago when she was working in a cubicle and was "dared" by another employee who didn't think she could "handle" work as an EMT. She spoke about stepping out of her comfort zone and finding a job that she loves and truly enjoys.

I asked if she had any additional information she wanted to share, which she declined. I thanked her for her time and we walked out of the university library together. I reminded her that I would be sending the transcribed copy for her to review. I had an hour and a half drive home which provided me with a period of time to think about the interview. I reflected on her calm demeanor and how her confidence level has greatly improved over the past eight years. As soon as I got home I wrote notes down regarding the thoughts that I had. I was happy with the interview. It was my first interview with a female and my first interview with a participant providing EMS services in a larger town. I was curious to continue my individual interviews to gain further understanding of these experiences.

The above narrative provides a review of participant #4's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #4 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 5. Participant #4 Supporting Statements**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>It just imprinted on me...</i>  <i>Adrenaline rush</i>  <i>...a little bit like waking up, you know, you can feel yourself calming down and feeling everything like slowing down a little bit better</i>  <i>...I do get the adrenaline rush just to get my job done</i>
Lived space	<i>We got in there, the room was still full of smoke from the gun</i>  <i>...it was just her emotions was just so raw and just, there was nothing to do</i>  <i>...and we had them in our truck and just stood around</i>  <i>I've had family members standing over me screaming you know, right in my ear. Trying not to pay attention that I'm kneeling on trash and needles</i>  <i>...I know everyone is looking at us to have that yes or no [alive or deceased]</i>
Lived time	<i>...it was like slow motion to me almost</i>  <i>And I think it's not as hard now, because of the fact that I did go through one early on...every case after the first one is a little bit easier I think</i>
Lived relationship	<i>...what do I say to people? What do I do?</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>...yeah, I remember just about every detail of it</i>  <i>Well, early on...I'd get home and I'd wonder you know if this was the right job for me.</i>



Why?	<p><i>...why it was so significant to me, is because he waited until his mom got home...and he just shot himself right in front of her</i></p> <p><i>...I can't blame anyone for it you know, but I feel like there are definitely reasons for those kinds of things</i></p>
Negative emotions/burnout	<p><i>...how can I keep facing this</i></p> <p><i>...I started using coping mechanisms I saw my coworkers doing. Where a lot of them eat too much, drink too much, and swear too much...</i></p> <p><i>...it's senseless that they tried this whether it was completed or not</i></p>
Support services	<i>...at first what everyone thought of me and all of that just was always weighing on me and it was really hard</i>
Shock factor	<p><i>...there was nothing to do</i></p> <p><i>...not being able to help at all with anything</i></p> <p><i>And I just didn't know what to do and just stood by the mother, just in case someone could tell me what to do</i></p> <p><i>...I think that's why I remember it so well...I went to the scene and I had no idea what to do...</i></p>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>Writing it all down...I would get home and I would just type it all out, type the whole call out and I felt like I was just putting it away</i></p> <p><i>...testing myself to know the limits of my strength has kind of given me that confidence that I have now...</i></p>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<p><i>So when I leave work I leave work there and I don't take it home with me</i></p> <p><i>As senseless as they are you know it's completely out of my control</i></p> <p><i>And I can't hold that on me</i></p> <p><i>Stop carrying those calls with me</i></p> <p><i>...whatever's happened to them has already happened...</i></p> <p><i>...I can't hold it on me as my own fault or my own responsibility</i></p>
Support	<i>Just knowing that even when I'm on a call, just knowing that he [her husband] knows that I can do it, really makes a difference</i>

	<i>...letting off the steam (peer support)</i>
Detachment	<i>I don't emotionally like attach to it</i>
Acceptance	<i>The worst thing that could possibly happen to that person has already happened. And I really accepted that</i>
Family become patients	<i>...just focus on your patient and then focus on the family if the patients gone</i>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>I love it</i>  <i>...just being able to go in and say I know what to do and taking that weight off the family members, I love that about my job</i>  <i>I do absolutely love my job and I was really lucky enough to find something I'm very passionate about</i>

**Individual interview #5.** The fifth interview was conducted with a 56-year old female (did not identify ethnicity on demographic questionnaire) who has been in EMS for 25 years. She identifies as a paramedic and has been in the position of chief for the past nine years. She noted that she has responded to at least six completed suicides on her demographic questionnaire and did not identify with having personal loss to suicide.

The interview was conducted at her office in her place of employment where no other individuals were present. We initially met outside of the office and as we walked into her office we briefly spoke about the town she resides and works in and her role as a paramedic and chief. This conversation helped to build a rapport with her. Prior to the interview, she was sent a copy of the consent form, demographic questionnaire, a recruitment letter, and a recruitment flyer, which we reviewed again prior to the start of the interview. I emphasized that participation in this study was voluntary and that she could leave the study at any time. She acknowledged voluntary participation and chose to participate. I informed her that I would be emailing her a

copy of the transcription of the interview for her to review. I also let her know that I may be taking some notes throughout the interview process. I reviewed the snowball-sampling recruitment approach and asked that if she had any names or contacts of individuals who may also may be interested in participating to please write them down or send them via phone or email. At this time she did not provide any information and did not follow up with a phone call or email. Following the review of materials and this information, she voiced an understanding and agreed to participate. Her signature was obtained on the consent form and she completed the demographic questionnaire. The interview lasted about one hour and 27 minutes at which the participant expressed that she did not have any other information to provide.

Following a review of the above information, we immediately started the interview. The first question I asked participant #5 was to describe her experiences of responding to completed suicide calls. She described arriving to approximately six suicide calls in her 25 years in EMS. Initially, she talked about how she is not always informed that the call is a completed suicide and doesn't know until she arrives at the scene. She described the areas in which she services as small and that she has responded to families that she had knew through other calls, "...so you get to know people and the one that committed, that shot himself, we knew the family through other children." She spoke about this family and the multiple tragedies they have encountered and how the police responded to the scene, "relieved that the cops were the buffer." She further provided specific examples of the suicides in which she has responded to. Another individual she responded to was a male who completed suicide and had been a prior patient on multiple occasions, "The worst part and what bothered me more about that one in particular, than any of the other ones was the previous time we had taken him, he made a comment that later impacted her, 'Oh just take me to Dr. Kevorkian,'" the doctor who engaged in assisted suicide. I sensed

some feeling of responsibility when she stated, "...and you wonder had I had said something about the Korevikian comment, would that have made a difference?" She then expressed concern for his wife, "...the worst part was nobody told the wife what was happening." She described that he was in a separate bed and he had shot himself in the middle of the night. There was no visible entry wound which she described made the cause of death more difficult, but later described that he had shot himself into the soft pallet of his upper mouth. She stated, "we didn't tell her either, I don't know that it was... our position to tell her...if I had to do over again, I would have told her." She further elaborated on another elderly self-inflicted gunshot where the man shot himself in front of his wife. She described the scene, "...there wasn't a whole big dramatic scene of any kind there....it was sort of subdued I think they were just in shock." She does not believe family members are an obstacle as the police officers are often on scene and keep family members away.

We segued our discussion into discussing boundaries in EMS. She described her role with the patients:

...you focus on the patient, um, the medics who don't focus on the patient, who allow themselves to get tied into the family drama, don't last. You can't take that with you. And I can't even tell you what any of these people really look like.

She describes an ability to maintain focus on the patient and what medical procedure she needs to do, "But the suicides are, they've never been overly traumatic for us, for me. Now I'm sure they are others, cases. Where there are people who have been." I asked if this has changed for her over years and she responded, "Not the suicides themselves. I can't say that there..." I sensed that she has set boundaries to maintaining a personal distance from family members and that

suicide completions have not triggered an emotional response from her throughout the years.

However, she did reflect on the increased frequency of drug and alcohol and psychological calls:

...the number of calls that we get that involve psychological issues, or drugs and alcohol, have become, instead of being maybe 5% or less of our calls, to I'll bet were approaching 20-25% of very, very, high percentage of our calls deal with drugs, alcohol, and psychological issues. Threatening suicides... attempting suicides... most of the attempted suicides are not serious attempts.

She questioned whether the increase in psychological calls was due to the closing of psychiatric hospitals in the state and also stated, "...were seeing it out of residents too... and a lot of repeaters...and which we've always had certain repeaters, we've had some real winners over the years." I asked her to further elaborate on her experiences with suicide attempts. She described, "Well what we often get called for is somebody will call and say, oh they took 50 pills... and that was just to get the family's attention." "...then you get the cutters." "...The serious ones use guns usually. We've had a couple hangings."

Yeah, I mean if your going to choose a way to kill yourself, that's the way to go [guns/hangings]. And, I mean... it, it's sort of sad in EMS, we sometimes, because you'll get the same person who will threaten suicide over, and over, and over again. And it's like can we publish a handbook that says if you really commit suicide, here's some suggestions. I mean, if you really, really want to do it, then do it. If you just want to, and just say you want help.

She again reiterated the impact of suicide calls on her, "...they're not any harder than any of the natural deaths." I asked if she had any other information about the impact of these calls which she responded, "not a whole lot." She did describe knowing another EMS personnel who had

completed suicide following an illness which she describes is “much different” than her role as an EMS provider and was thankful that she didn’t have to have respond to that call. She continued to discuss other scenes of traumatic calls scenes that she has encountered and how people cope with the loss of loved ones. She describes her role in contacting family or friends to come to the scene to support the loved ones at their time of need. She described arriving to “death” quite often in her role, “...we do dead a lot, we’re pretty good at that.”

She continued to discuss various types of calls and started to talk about the uncertainty about death. She described a recent call of a couple who were known in town to have problems with addiction and had recently been discharged from the hospital for overdose. She reported that they later died from overdose following their hospitalization, “...are they that stupid or did they intentionally try to kill themselves?” I reflected feelings of frustration with addiction or taking calls of overdose. The conversation shifted to a discussion about working with new EMS personnel who are young and inexperienced:

Particularly at the moment and throughout the years, we get a lot of kids. Um, 18, 19, 20, fresh out of EMT school and you have to be a little sensitive to them. Those of us, right now we have four medics who are all over 50, okay, all of us who have been in the field for a minimum of 10-15 years, so were hardened.

She further elaborated on providing support to new EMS personnel, “You don’t criticize, you don’t yell, you just guide.” I asked about additional support services for the paramedics and EMT’s, which she described having experience with debriefing between peers. She explained that she takes on the supervisor role in debriefing with younger staff and setting up critical incident stress debriefing (CISD) teams for difficult calls. She personally described attending CISD in the past, specifically recalling her “most traumatic call.”

I would say the most traumatic call I ever had was years and years and years ago, and it was a murder. A woman that was beaten to death and I was young and new at that point. That's when I decided to become a medic instead of just being an EMT. Because the medic there was overwhelmed and had there been another medic could that could have stepped in and said okay, this is what we need to do.

She further stated,

That was hard and like I said I was young and had just been in the field and to come face to face with a violent death, at somebody else's hands, is a little bit different than an a violent death at their own hand.

It appeared that she had more frustration with individuals who do harm to others, rather than inflicting harm on themselves. At this time I felt it was important to ask her how she continues to make sense of arriving to trauma calls, such as suicides, or the murder she described:

I think what, it's not making it personal. You go to an accident scene and you take care of an accident, where you count the number of victims, wherever, depending on what your situation is. Um, you just, there are times when you go home afterwards and you wonder why in the world this happened, but most of the time, now I'm a religious person, so maybe that helps me.

I asked her if she meant that religion was a way of coping for her, which she validated, "It's been able to vent through prayer." She further described learning to have a "sick sense of humor" and credits this as a coping mechanism for her and her crew. "...And there's always the call that bothers you a little more than the other one" and "I find myself getting a little bit impatient with the people who won't help themselves," "...I think those are the people that frustrate me." She took some time to further elaborate on her frustration with patients who tend to call frequently

without making significant changes in their life to help themselves. This lead into the last question about how she sustains her work as a paramedic. Her response was “I can say for the most part I don’t get involved.” I reflected on some of her responses, which she has previously mentioned, including limited personal involvement, her faith, and the sense of humor, which she had described. She also further described the calls that give her hope:

...it’s a very uplifting call to deliver a baby to somebody who wants that baby, who you know, deliver a strong, healthy, baby and hand it over to a mother who already loves it, and this is a beautiful thing, and you could live a long time on that, but you know, those things are... sometimes you just hold somebody’s hand on the way to the hospital to give them a little comfort, and its nice, or you get somebody who comes by later on and sends a thank you note or whatever and there are some patients out there that just lift you up.

She reflected on more difficult calls, “You can count on that being over...”

...but you gotta take the good with the bad. Now I always say, I can put up with anything for an hour. And we rarely have a patient longer than that. So we don’t have to, no matter what, it’s going to be over.

She spoke a little more about the feeling of reward from optimistic patients and how that helps to sustain her work as a paramedic. I asked if she had any additional information to share with the topics we had discussed today, which she declined. I turned the digital recorder off and thanked her for her time today. I reminded her that I would be emailing a copy of the transcribed data for her to review. Again, I had about an hour and a half drive home which helped me to think about the study and clear my thoughts. When I got home I made sure to write notes down regarding these thoughts. I was happy with how the interview went. I started to see patterns and themes that were developing among participant interviews. I noticed that her responses were somewhat



similar to participant #1 with attempts to disconnect with her work, specifically in a leadership position. Some of the other participants also mentioned this and I was starting to gather that this was essential in EMS.

The above narrative provides a review of participant #5's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #5 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 6. Participant #5 Quotations of Significance**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>n/a</i>
Lived space	<i>...there wasn't a whole big dramatic scene of any kind there...it was sort of subdued...</i>  <i>That was hard and like I said I was young and had just been in the field and to come face to face with a violent death, at somebody else's hands, is a little bit different than a violent death at their own hand</i>
Lived time	<i>Not the suicides themselves, I can't say that there [emotional response]</i>  <i>...because you'll get the same person who will threaten suicide over, and over, and over again</i>
Lived relationship	<i>...so you get to know people and the one that committed, that shot himself, we knew the family through other children</i>  <i>...you have to be a little sensitive to them</i>  <i>...we've had some real winners over the years</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>n/a</i>
Why?	<i>...there are times when you go home afterwards and you wonder why in the world this happened</i>  <i>...are they that stupid or did they intentionally try to kill themselves?</i>
Negative emotions/burnout	<i>The worst part and what bothered me more about that one in particular, than any of the other ones was the previous time we had taken him, he made a comment about, oh just take me to Dr. Kevorkian...</i>

	<p><i>I find myself getting a little bit impatient with the people who won't help themselves</i></p> <p><i>...And there's always the call that bothers you a little more than the other one</i></p> <p><i>...the medics who don't focus on the patient, who allow themselves to get tied into the family drama, don't last</i></p>
Support services	<i>n/a</i>
Shock factor	<i>I think they were just in shock</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>...it's been able to vent through prayer</i></p> <p><i>But the suicides are, they've never been overly traumatic for us, for me</i></p> <p><i>Sick sense of humor</i></p> <p><i>...now I'm a religious person, so maybe that helps me</i></p>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<p><i>You can count on that being over [difficult calls]</i></p> <p><i>...you gotta take the good with the bad</i></p> <p><i>...no matter what, it's going to be over</i></p> <p><i>You can't take that with you</i></p>
Support	<i>...relieved that the cops were the buffer</i>
Detachment	<p><i>...they're not any harder than any of the natural deaths</i></p> <p><i>...I can't even tell you what any of these people really look like</i></p> <p><i>...it's not making it personal</i></p> <p><i>...so we're hardened</i></p> <p><i>I can say for the most part I don't get involved</i></p>
Acceptance	<i>n/a</i>
Family becomes patients	<i>n/a</i>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>...there are some patients out there that just lift you up</i>

**Individual interview #6.** The sixth interview was conducted with a 57-year-old Caucasian female who has been in EMS for the past 37 years. She identifies as a paramedic, and described having additional training in Business and Public Relations. She is currently working full-time as a paramedic in a power plant and part-time at an ambulance company providing services at special events (e.g. sporting events). Prior to her work at the power plant, she was employed at an ambulance company for many years. She noted that she has responded to about 10 completed suicide calls on the demographic questionnaire and responded “yes” to having personal experience with suicide, which she had previously informed me during our phone call to set up the interview.

The interview was conducted in a private office space at her place of employment. This room provided a quiet space for her to discuss her experiences without the presence of other individuals. When I arrived she told me she was currently working and that if an emergency occurred that she would need to leave the interview. I ensured that we could stop the interview at any time and that I could come back to complete the interview if she desired. Prior to our interview, she was provided the consent form, demographic questionnaire, a recruitment letter, and a recruitment flyer. We took time to review these documents again prior to the start of our interview. I made sure she was aware that participation in this study was voluntary and that she could leave at any time, which she acknowledged. I informed her that I would be emailing her a copy of the transcribed interview within a couple weeks for her to review for accuracy. I also let her know that I may be taking notes throughout the interview process, which at this time she stated, “...I went through 21 years of psychotherapy, so I’m used to people writing and talking...” I reviewed the snowball-sampling recruitment approach and asked that if she had any names and contact information of EMS personnel who also may be interested in participating

that she could provide those today or via phone/email. She did not provide contacts at the interview or follow up via phone or email. Following the review of materials, she voiced an understanding and agreed to participate. Her signature was obtained on the consent form and she completed the demographic questionnaire. The interview lasted approximately one hour and 14 minutes at which at this time the participant expressed that she did not have any other information to provide.

Following a review of the information and a brief discussion about her role in both of her areas of employment, I asked participant #6 to describe her experiences of responding to suicide calls. Initially, she spoke about how suicide calls have minimal effect on her, “....doesn’t really bother me.” Without prompt, she started discussing trauma calls in general and how she provides support to patients when she first arrives to the scene, “The worst is over, I’m here now, the worst is over.” She described communicating this statement to most patients to bring them comfort, but primarily to empower herself, “...to convince myself that I can handle this.” She described learning self-talk through her own psychotherapy and has developed “multiple personality” to survive many events in her life. I prompted her discuss how she got into the field of EMS:

And so that was a huge disappoint in my life [accepted into a music program but her parents didn’t allow her to attend] so when I became an adult, I made my own decisions about what I wanted to do and this [EMS] was perfect. I fit right in to it and when it started out, it started out something to do until I figured out what I wanted to be and then it ended up being my job.

She further spoke about a history of personal trauma in her own life. She described having a difficult childhood with her mother who attempted suicide continuously throughout her life and

family members who continued to inflict abuse on her. I provided support and reflected on how a personal history of trauma helped her to identify EMS as a career for her.

At this time I redirected the conversation to her experiences of arriving to completed suicide scenes, she stated “it’s easy,” “the deeds done already,” and that her main priority becomes the family at that time. She is required to call the coroner at this time or the family doctor and will then “clean up the mess” to prepare for transportation of the body. She spoke about how others have asked her how she has handled suicide calls and she responded, “It helps when you grow up with someone who’s trying to do this all the time. You know what I mean, so nothing surprises you.” She then spoke about her mother who completed suicide following many attempts in her childhood:

And in my case, I was a paramedic and I tried to tell people you know this woman shot me once with a shotgun, she stabbed me, she’s done everything that she could do to me and at, at some point you just get numb you know, and she’s taken pills and drinking whisky, you know, you just, you don’t see things, you get blinders on, it’s like it’s not that you don’t care, it’s just that you don’t care, you’re tired you know. And in that case that’s what happened.

I offered my condolences and she continued to express childhood events that caused significant stress, including the time her mother shot her with a bb gun. She spoke about how childhood events shaped her into the paramedic that she is today, “Oh yeah, it’s made me one of the better paramedics in this county. That’s what I said people, I don’t let it go to my head.”

She had initially spoke about her role to help the family and I asked her to reflect on the presence of loved ones at suicide scenes.

...well I think I use my experiences when my, I meet other people you know that are in these shoes. And it helps for someone to say I know how you're... I lost my mother to suicide. It's amazing how it changes the whole demeanor of what's going on when you say to somebody and they just kind of look like you and its like oh my god, how did you deal with that. You said you deal with it. You know, you just, this will pass you know you just have to realize don't take it on, it's not your responsibility. You didn't do anything wrong. It was something going on in their mind.

She began to reflect on the initial feelings of guilt she experienced following the loss of her mother and started to discuss her concern for her niece who is experiencing symptoms of depression. I provided an opportunity to let participant #6 reflect on continued personal stressors, but worked to maintain boundaries within the interview process. At this moment, I thought about asking participant #6 if she would be interested in returning to counseling services and that I would help to make a referral for services, but she later confirmed in the interview that she felt she completed counseling services years ago and learned a lot about herself through therapy, which she no longer needed.

The discussion segued into a reflection about responding to a suicide where she had prior relationships with the patient. She then began to speak about a suicide attempt she responded to and heard the gunshot as she was walking into his residence, which she learned was a male she had known, "...when you walk in a situation that somebody you know like that, and it's like are you, are you stupid... why do you do this? She spoke that most of the time she has difficulty understanding the action of suicide, but spoke about a difficult time in her life which she had considered suicide and had received the appropriate help, "Yeah exactly. I mean I'm here to tell about it now and I just you know, I don't how I made it through that, if it wasn't for my

therapist.” She spoke about how she takes on the role of a counselor that she takes on when responding to suicide calls:

...if it’s something scaring you, talk about it. Once it comes out of your mouth, it has no control over you anymore. You know, so that’s what I tell my families. If I go to their houses and I find loved ones who have taken their lives or something, lets talk about what, how your feeling.

She elaborated the on the reward when family will come back later and tell her what a difference she made in that time of need, “Somebody was a guardian angel for me and I had the opportunity to pass it on you know.” I asked her to elaborate on the impact this has on her:

...so if I say the right words and show the right compassion, then somewhere down the road, somebody’s going to do, that person’s going to do the same for somebody else. It’s kind of like passing, passing it forward you know or whatever they call it, but to me that’s, that’s what I do. That’s who I am.

At this time I summarized the way in which she has coped with difficult calls including suicide completions, and emphasized client’s reported faith as a big part of her life. She further spoke of the “weird positions” that she believes God has placed in her in. An example of this included a more thorough discussion of responding to suicide completions/attempts, which she knew the person. She provided a specific example about arriving to a suicide attempt where she knew the person who had treated her badly in childhood and she later responded and helped save their life. She then spoke about arriving to another completed suicide call where the individual was a relative of hers, “I was a young, young paramedic, got called to a guy who walked into a minimart and blew his head off,” where she later found out it was a distant relative. Although she spoke that suicides of known individuals were difficult, the most difficult patients are described

as, "...I think youth suicides are the hardest for me. It's hard for me to, I mean, I understand because I've been where they are..." She further stated, "I've had a few young kids who lost their boyfriends or blew their heads off... or you know, it's not worth all that." She described the impact, "You know and those bother me. Because nobody cared enough, to intervene, or just say 'Hey I loved you, what's going on?'" I asked her to reflect on how the impact of these calls has changed throughout the years, "I don't. I don't think that it, I mean, I guess I feel kind of numb to it. You know. I just, you don't know what you're going into." She spoke about the uncertainty of the scene before arriving and how difficult this is. She described an experience where she arrived on scene to a man who was fatally shot and that his friends put her on "a list to be killed" since they didn't like the way she provided services, and were eventually caught by police. She talked about how her safety is of primary concern:

So for me, that's the way it is with the suicides. You know, you don't know are you really going into a suicide or is this a set up, you know. I mean our paramedics are wearing bulletproof vests now because it happens quite frequently in our county.

She began to talk about how she has coped with "mental health calls," "Eventually you just get kind of hardened to it and you realize that people, some people have genuine mental health issues that cause them, they don't know any other alternatives, and other ones are just stupid." She spoke about other coping mechanisms, "I have an ornery sense of humor," and her faith, "...all you can do is pray for the family and their soul." At this time I asked about any debriefing services offered to her, which she described attending critical stress debriefing teams, and additional counseling services with "mental health" through their employee assistance program. She spoke about utilizing debriefing teams following a plane crash that she responded to and the post trauma symptoms she experienced,



... I got there when the engines were still running, so the roaring of the engine's sounds like the turbines on this turbine deck, so I freaked out for about 3-4 days, I couldn't come here, because I couldn't hear the turbines.

In addition to professional debriefing teams, she spoke of the peer support, "...in our crew lounge a lot of stuff happens... people cussing and people from everywhere. From, laughing and you know, I have to say that many of us don't cry because we were pretty much hardened to all." She also described feeling "hardened" to maintaining contact with patients who have previously attempted to harm themselves, "...he's my friend on Facebook. You know, so I guess you get kind of hardened to it."

We continued the discussion of how she makes sense of her continued exposure to trauma as a paramedic.

I kind of pat myself on the back, 'cause I got them out of here alive. You know and so for me, it's a pride kind of thing. Not to the point that I want somebody to say, "Man look at what you did. She saved that guy's life." I don't want that recognition. But if somebody's going to say something about me, "she was really humping to get him out of here alive."

You know what I mean, and after it's all said and done, I can take a deep breath and realize what just happened. I pat myself on the back and then I go on.

I continued this discussion and prompted her to talk about how she makes sense of the loved ones and family members who are present at scenes. "I, I've always been about the family." "...it's something that, that's how I make sense of it. Once I've done what I can do for the person that I was called for them I try to make the family's life easy." "...just make sure that everybody's taken care of, that's my job." She spoke about going the extra step with family, "...then when I get off duty and get a little bit of sleep, I go back to the hospital and make sure

their okay.” She continued to speak about her childhood and past issues with people who bullied her and later had these individuals as patients or loved ones of patients,

I’ve worked through all that stuff and yeah it effected when it was going on, it effected me for a little while longer afterwards when I became an adult, but I’ve talked about that and that powers not there anymore.

She spoke about gaining control in her life and how her role as a paramedic has helped her to do that, “...I think being a paramedic gives us a sense of control that we never had before.”

At this time, I heard a lot of information about how participant #6 has maintained her work as a paramedic, but I asked her if she had any additional information to add to this. She spoke about a desire to look for another job, as she has not “run a crew” in quite some time and is concerned, “it’s not second nature to me anymore.” She talks about having hopes of working a less intense job, “Something that don’t involve saving peoples lives. That gets, it gets hard.”

The meeting appeared to be coming to an end and I asked if she had any additional information that she wanted to add. She stated that she had put some time into thinking about the topics being discussed prior to our meeting and stated, “...I never realized after I started thinking about it, that I had more that survived than actually died.” She spoke a little more about the work that she does as a paramedic and when she finished up I thanked her for her time today and I turned off the audio recorder. I reminded her that I would be sending her a copy of the transcribed interview for her to review. I went to my car and wrote a few notes down about the interview process and when I got home and reflected on the interview, I wrote a few additional notes down. I was happy with how the interview went and noticed how participant #6 spoke a lot about personal traumatic experiences and her personal loss of a suicide with her mother and how this has reflected in her work as a paramedic.

The above narrative provides a review of participant #6's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #6 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 7. Participant #6 Supporting Statements**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
<i>Lived body</i>	<i>n/a</i>
<i>Lived space</i>	<i>I fit right into it</i>  <i>Clean up the mess</i>  <i>...when you walk in a situation that somebody you know like that...</i>
<i>Lived time</i>	<i>...this will pass you know</i>
<i>Lived relationship</i>	<i>...I use my experiences when my, I meet other people you know that are in these shoes</i>  <i>If I go to their houses and I find loved ones who have taken their lives or something, let's talk about what, how you're feeling</i>  <i>I've always been about the family</i>  <i>...just make sure that everybody's taken care of, that's my job</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>n/a</i>
Why?	<i>and it's like are you, are you stupid...</i>
Negative emotions/burnout	<i>...I think youth suicides are the hardest for me</i>  <i>...and those bother me</i>  <i>Something that don't involve saving peoples lives. That gets, it gets hard [a desire to find another job]</i>
Support services	<i>n/a</i>
Shock factor	<i>...you don't know what you're going into</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<i>I was a paramedic and I tried to tell people you know this woman shot me once with a shotgun, she stabbed me, she's done everything that she could to me and at, at some point you just get numb...</i>

	<p><i>I have an ornery sense of humor</i></p> <p><i>...all you can do is pray for the family and their soul...</i></p> <p><i>...to convince myself that I can handle this</i></p> <p><i>...I understand because I've been where they are</i></p> <p><i>It helps when you grow up with someone who's trying to do this all the time [mother attempting suicide]. You know what I mean, so nothing surprises you</i></p>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<p><i>...if it's something scaring you, talk about it. Once it comes out of your mouth, it has no control over you anymore</i></p> <p><i>I pat myself on the back and then I go on</i></p> <p><i>...after it's all said and done, I can take a deep breath and realize what just happened</i></p>
Support	<p><i>The worst is over, I'm here now, the worst is over (providing support)</i></p> <p><i>I don't know how I made it through that, if it wasn't for my therapist</i></p> <p><i>...in our crew lounge a lot of stuff happens... people cussing and people from everywhere. From, laughing and you know...</i></p>
Detachment	<p><i>...doesn't really bother me</i></p> <p><i>I guess I feel kind of numb to it</i></p> <p><i>The deeds done already</i></p> <p><i>...I have to say that many of us don't cry because were pretty much hardened to all</i></p> <p><i>...so I guess you get kind of hardened to it</i></p> <p><i>Eventually you just get kind of hardened to it and you realize that people, some people have genuine mental health issues that cause them, they don't know any other alternatives, and other ones are just stupid</i></p>
Acceptance	<i>n/a</i>
Family become patients	<i>...then when I get off duty and get a little bit of sleep, I go back to the hospital and make sure their okay [visiting family members]</i>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>

4. MEANING OF EXPERIENCES	
What I get from the work	<p><i>...I think being a paramedic gives us a sense of control that we never had before</i></p> <p><i>I kind of pat myself on the back, 'cause I got them out of there alive. You know and so for me, it's a pride kind of thing</i></p> <p><i>Oh yeah, it's made me one of the better paramedics in this county</i></p> <p><i>...but to me that's, that's what I do. That's who I am</i></p>

**Individual interview #7.** The seventh interview was conducted with a 32-year-old Caucasian male who has 10 years of experience in EMS and identifies as a paramedic. He works as a paramedic within an ambulance company and is also currently enrolled as a full-time student. His training includes firefighting, some college, paramedic certified EMT-P, and other certifications, including his current educational program. He identified “yes” to having personal experience on his demographic questionnaire and noted that he responded to about 30 completed suicides as a paramedic.

The interview was conducted in a private room at his university library. This room provided a quiet and confidential place for him to openly discuss his experiences without the presence of others. He had been provided with the consent form, demographic questionnaire, a recruitment letter, and a recruitment flyer prior to our meeting. I introduced myself to him and emphasized that participation in this study was voluntary and that he could leave at any time. He acknowledged voluntary participation and chose to participate in this study. In addition to the time he spent reviewing the documents prior to our meeting, we spent time reviewing the consent form. I informed participant #7 that I would be emailing him a copy of the transcription of the interview within a couple weeks for him to review and check for accuracy. I also let him know that I would be taking field notes throughout the interview process. I reviewed the recruitment approach of snowball sampling and informed him that he could provide the names and contact

information of paramedics and EMT's whom he believes may be willing participate. Following the review of materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form, he completed the demographic questionnaire, and I then began the interview. The interview lasted approximately one hour and 13 minutes at which the participant expressed that he did not have any other pertinent information to provide.

After reviewing the documents and materials, I began the interview. Initially, I asked him about how he got into the field of EMS. He spoke about being in EMS and fire services since he was 14 years old when he started as a junior fire program and has been a paramedic for almost 10 of those years, "...pretty much half of my life I've been doing this." He spoke about getting out of EMS when he met his wife and had their first child and entered an unrelated field. He went back to EMS after two years and is now enrolled in a college program for another medical field, "...as far as like body mechanics and then the burnout factors, and the amount of money that you make, imperatively nursing is just the next inevitable step."

I asked participant #7 to describe his experiences with responding to completed suicide calls. Initially, he spoke about the types of suicide calls:

I've been to a lot of suicides, most of them are completed. Most of them are not workable, which we refer to as trying to resuscitate somebody. Um, I would say a majority of suicides are gun related in my experience. Um, and followed by a lot of drugs that are associated with them, and then usually hangings after that. Which is very rare.

I've only had three in my career.

He spoke about how suicide by hanging are "the creepiest by far," "...they don't look as dead as a normal dead person" and how those who die by hanging tend to hide themselves, "...they seem

more bitter and leave a suicide note whether they hang themselves... there aren't many people that I've seen leave suicide notes." He further described the scene at a suicide call, "...the scenes not very chaotic typically, but it's more somber, very somber scene." Without prompt, he started to talk about the family and loved ones at the scene, "...as far as family goes, and how they react, it's all very different. "I would say anger and denial in general, bewilderment, are probably the three things to describe family members on a suicide scene." He talked about the shock that family and loved ones tend to have at a suicide completion scene, "...it doesn't seem like family realizes that they were going towards that path. They feel like it's a shock like it's some abrupt thing and they never knew they thought about this or..."

He started to talk his experiences with responding to self-inflicted gunshot wounds. He spoke about a female with a self-inflicted shotgun wound, which he described as "rare." He also described a self-inflicted gunshot at an assisted living facility where the individual left a suicide note. "...it's a bit traumatizing to read them, I don't think I've ever read in completion," "...but in my opinion, it's not really my business." He spoke about how suicide notes appear "...very positive," with only one note that was negative.

At this time he started to reflect on past memories of suicides:

I've been thinking about these suicides for the past couple of days, thinking about coming to this meeting, and every time I think about one, like another one pops into my head. Because it's hard because I think you compartmentalize things that you see like that. But you never forget them. Like, I can see the scene right now, you know what I mean. Like walking in, exactly what I found, who it was, kind of weapon it was, what family members were on scene. But, you compartmentalize it and it just kind of, you just kind of

shoot away into a special place in your brain I guess. It just stays there but you block it off so that it doesn't bother you.

At this time I felt the need to inform him that if the conversation felt too difficult that he could stop any time, which he stated, "Oh no, it's fine." He further elaborated:

So you can't let it be at the forefront of your mind constantly and let it bother you. You know what I mean? It doesn't make any sense to do that. I think that's kind of a logical way of thinking versus an emotional response to the situation. Because you just know that like, if I think about the last 10 suicides that I saw, your just going to be depressed and irritated and angry and all those emotions that well up inside of you whenever you have to go on one of them.

I noticed the empathy which he provides to his patients and their loved ones, but has maintained boundaries as a form of self-care. He spoke about how the job tends to be stressful anyways and you must maintain your emotions to not reflect emotions on to the patient. He spoke about being "empathetic...definitely not sympathetic, that won't help you." "Sympathy will, I think makes you weaker whenever you do healthcare, because then you become too emotional about what you see and you can't do that." He summarized his response, "empathetic with boundaries." I asked that if he had any additional information on the impact that suicide calls have on him where he further emphasized "compartmentalizing things". He further spoke about self-care in his role, "...when I go home, I don't really talk about it too much." He talked about keeping his job at his job, "...I'll keep the conversation for between friends in EMS and then I try to really divide home and work..." He further elaborated on meditation as a form of self-care for him where he attempts to do a minimum of 10 minutes per day. I asked if the impact



has changed over the course of time for him, where he stated, “I would say the impact is less” of responding to completed suicide calls.

More experience and the easier it is to compartmentalize it and along with compartmentalizing it, I think that you just accept it. You know what I mean. For what it is. You’re not going to change it. You’re not going to change that behavior in, in the role that we have. So you have to just kind of deal with that stressor as it comes along and allow it to you know, level itself out by talking to people or meditating or relaxation of whatever you can do but I think it becomes easier and I think that you know, I don’t know if this is a good thing, but you’re empathetic but you have no sympathy anymore. He spoke about witnessing trauma “push people [EMS personnel] out.” With experience, he personally believes he has matured and learned to cope with his work in EMS.

...it’s not as exciting anymore but that’s kind of good. It becomes more of a flat affect for you. Like if I get a call for someone that’s dying, I don’t, my heart rate doesn’t increase and I don’t start to sweat you know what I mean. But when I was brand new, you’d be totally nervous.

He spoke about the frequency and quantity of trauma calls he receives, which he believes has helped him to reduce anxiety, “...I think it’s interesting that your doing suicide...’cause I think that it is a traumatic thing, but I think that something that is more chaotic is trauma in general.” He elaborated on the chaos of trauma scenes including other first responder agencies, bystanders and loved ones around, the noises of the ambulances and fire services, etc.

... so the fire’s looking at you, cops are looking at you, your EMT’s looking at you, the public’s looking at you, the patients looking at you, so it can be very stressful especially

when you're a new medic, you know to be like okay. You can't really think about that like everyone's staring at me, do this...

I asked him to define 'trauma' which he identified traumatic incidents such as a car accident a large fall, or an industrial accident. He started to discuss how suicide scenes again are much more quiet and how family are often left wondering what happened and why, "...they're very quiet scene..." As opposed to trauma scenes, which tend to be much more loud and chaotic, with bystanders and family screaming. I asked him about the impact of those scenes,

...and that's without a doubt the hardest part is people that scream or cry or get really emotional that are connected to it. Because it's, and I don't mean this in a rude way, but it's very distracting. It's very distracting when they try to focus on what you're doing. But at the same time you understand what they're going through...

At this time he described an emotional and traumatic scene that he arrived to following a car accident and how it has impacted him,

...the kid that was in the car was screaming "Help me" literally from the time that we arrived on scene probably prior to that, 'cause we rolled up on scene, we could hear him and he screamed it from that time until he died in the back of our ambulance.

He stated "...That was a very traumatic experience" and how one of his EMS partner's quit following that call. He had constant reminders of the event, "...and the truck bled for like a week, every time we cleaned it out, it would come out of some crevice somewhere..." "Every time you opened the door, it was like this reminder in your life..." He remembered feeling a personal connection after learning information about this patient and how it made things more difficult for him. He described a desire to be able to "digest everything" and how this isn't always possible as another call may approach immediately following this type of scene. At this

time I summarized his responses about trauma scenes and how they are more difficult and chaotic than a suicide scene and leave more of an impact, which he agreed.

He described frequent encounters with the deceased as his ambulance company transports all deceased patients in the county to the morgue or funeral homes. He talked about enjoying working with the family members, "...you have a lot dealing with families in many, many facets and different situations with death and dying. So, but it's... I like it because first off it gives you a different perspective of each one, which is good." He also spoke about how transporting the deceased gives him a sense of completion, "...I like the fact that we do everything to completion," even with completed suicides:

...the one thing that EMS doesn't get to see a lot of is and I know this is a weird analogy, but the completion of something. You know, you don't, you take the person to the emergency room and you have no idea what happened to them 99% of the time. And these patients are deceased unfortunately, but at least you get to see it to the end, you know what I mean. You get to see the family to the end and make sure they have what they need, even though it may be very minimal and get the patient to where they need to go, and even though it's the end of their life, it's kind of the end of the call too.

We spoke briefly about peer support services and self-care earlier in our interview and I followed up with that discussion and asked him about any professional debriefing services that have been offered. He informed me that debriefing services are minimal within his company, as he responds to trauma scenes quite frequently.

Now don't get me wrong, I'm a huge advocate for it. Personally I think that were big enough that you have a manager that does that, that that's all they do, is debrief trauma, or debrief stressful situations. Or bring people and talk about it.

He further elaborated:

You kind of vent to each other which is good, but at the same time, sometimes a third party is better because maybe the people you were dealing with on scene that were part of your trauma, were part of the stress that caused you to have as much as the trauma that you did. So, talking to someone else and being able to, essentially having a bitch fest about what happened.

He describes a desire to see more professional debriefing services and how lack of services may be a "...contributor to burnout in healthcare." He believes engaging in debriefing is a personal decision and although some times it can be beneficial, he believes it can also make things more difficult, "...it opens the, keeps the wound open too much." He does not believe that he personally needs debriefing services following difficult calls.

I asked if he had any more information on arriving to suicide attempts, as we had briefly spoke about them. He provided two specific examples of self-inflicted gunshot wounds and he spoke about his response to his first suicide attempt at age 21:

One was an elderly man who blew his whole jaw off and we had to hold his tongue out to stop it from going back into his throat because it would just close his airway right off, because he had no control. You know. And uh, that was one of my, that was my first ever suicide attempt.

I asked about the impact of this method of suicide attempts which he describes as "more impactful," as opposed to other methods, such as hanging. He further elaborated on suicide attempts:

...even though it's a suicide attempt, it's not something that you uh, that you think about as much. Because you, you have to think about getting that person back, which is kind of

a traumatic thing in itself because your like, this isn't really my decision, you know what I mean? That was their decision to do what they wanted to do and now me, I'm forcing this upon them in a way.

He further discussed his thoughts about whether patients are satisfied or dissatisfied with helping them survive following a suicide attempt; a "strange" thought and something he never contemplated before. He does recall one prior suicide attempt where the individual was angry for helping to save him after he attempted suicide:

I've had a guy who took a surgical scalpel and cut both of his carotid, both of his brachials and both of his radials, and we got there and he was still awake. And uh, the whole time all he talked about was, he was very angry with us that we were there.

I asked if suicide attempts were more like the trauma calls he described earlier and he stated that they were, "...more like trauma...they're very, they're a lot more chaotic." This prompted him to discussing the "intimate experience" when you are working scenes with a lot of blood from patients,

...kid that got in the car accident, we had to decompress his chest a bunch of times and he was bleeding out of the decompressions and as we were doing CPR, his blood was just pulling all over our hands. So it was a very intimate experience.

Following a discussion of experiencing direct response to trauma, I asked how he continues to make sense of traumatic exposure. He spoke about how much he enjoys the job, "I love what I do," "I can compartmentalize it, and I really enjoy doing it..." "...I'm pretty good at it, so I like that about it," "...it's engrained in me, it's without a doubt who I am." I further asked how he makes sense of his work with continued presence of loved ones and family members. He responded, "I just think that's part of it, you have to learn to treat your patients, or your families

just like your patients,” “...they’re an integral part of what you do with patient care and you have to incorporate them...” He concluded the question with this statement:

I think it’s very similar to this but not similar to it, it’s similar to war. Because you are in very unpredictable situations that you only have so much control over and there’s a lot of trauma that’s happening around you that you can only deal with so much of it at one time. Although he had already reflected on the ways in which he sustains his work as an EMS personnel, I asked if there was anything that he wanted to add:

It is who I am, um, I mean I really enjoy doing it because I think when you stop learning, you start dying, that’s the personal philosophy of mine that you should always be learning and trying to learn new things and with healthcare as long as your someone who enjoys doing that, it’s never ending.

He spoke about looking forward to going to work each day and how he continues to enjoy his work in EMS. I asked if he had any additional information and he declined. I stopped the audio recording and as we walked out of the room he spoke more about his desire to continue his education in the medical field and continue to learn. Before I left, I reminded him that I would be emailing him a copy of the transcribed interview for him to review. Before I drove off, I wrote a few notes in my car about how the interview went. I was happy with the results and it was apparent that his compassion for the field was great.

The above narrative provides a review of participant #7’s descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #7 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 8 Participant #7 Supporting Statements**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<p><i>...digest everything</i></p> <p><i>...he blew his jaw off and we had to hold his tongue out to stop it from going back into his throat...</i></p>
Lived space	<p><i>The scenes not very chaotic typically, but it's more somber, very somber scene [completed suicide scenes]</i></p> <p><i>Like, I can see the scene right now...like walking in, exactly what I found, who it was, kind of weapon it was, what family members were on scene</i></p> <p><i>...they're very quiet scene [completed suicide scenes]</i></p> <p><i>...more like trauma, they're very, they're a lot more chaotic [suicide attempts]</i></p>
Lived time	<p><i>...pretty much half of my life I've been doing this</i></p> <p><i>...my heart rate doesn't increase and I don't start to sweat...(over time)</i></p> <p><i>...but when I was brand new you'd be totally nervous</i></p> <p><i>...I like the fact that we do everything to completion</i></p>
Lived relationship	<i>...empathetic with boundaries</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>But you never forget them</i>
Why?	<i>n/a</i>
Negative emotions/burnout	<p><i>...the creepiest by far [hangings]</i></p> <p><i>...they don't look as dead as a normal dead person</i></p> <p><i>That was their decision to do what they wanted to do and now me, I'm forcing this upon them... [attempting to revive suicide attempts]</i></p> <p><i>...more impactful [self-inflicted gunshot]</i></p> <p><i>If I think about the last 10 suicides that I saw, you're just going to be depressed and irritated and angry and all those emotions that well up inside of you whenever you have to go on one of them</i></p> <p><i>Sympathy is, I think makes you weaker whenever you do</i></p>

	<i>healthcare, because then you become too emotional about what you see and you can't do that</i>
Support services	<i>...it opens the, keeps the wound open too much [debriefing]</i>
Shock factor	<i>They feel like it's a shock like it's some abrupt thing and they never knew they thought about this or...</i>  <i>...it's a bit traumatizing to read them [suicide notes]</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<i>So you have to just kind of deal with that stressor as it comes along and allow it to you know, level itself out by talking to people or meditating or relaxation or whatever...</i>  <i>...empathetic...definitely not sympathetic, that won't help you</i>  <i>...these patients are deceased unfortunately, but at least you get to see it to the end...</i>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<i>...I think it becomes easier</i>  <i>...when I go home, I don't really talk about it too much</i>  <i>I would say the impact is less [over time]</i>  <i>...even though it's a suicide attempt, it's not something that you uh, that you think about as much</i>  <i>I really divide home and work</i>
Support	<i>I'll keep the conversation for between friends in EMS</i>  <i>You kind of vent to each other which is good, but at the same time, sometimes a third party is better... [debriefing teams]</i>  <i>...essentially having a bitch fest about what happened</i>
Detachment	<i>But, you compartmentalize it and it just kind of, you just kind of shoot away into a special place in your brain I guess. It just stays there but you block it off so that it doesn't bother you.</i>  <i>Compartmentalizing things</i>  <i>...you block it off so that it doesn't bother you</i>  <i>So you can't let it be at the forefront of your mind constantly and let it bother you</i>  <i>It becomes more of a flat affect for you</i>  <i>Because it's hard because I think you compartmentalize things that you see like that</i>



Acceptance	<i>I think you just accept it</i>
Family become patients	<i>...they're an intrical part of what you do with patient care and you have to incorporate them</i>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>I can compartmentalize it...</i>  <i>I'm pretty good at it, so I like that about it</i>  <i>...and I really enjoy it</i>  <i>I love what I do</i>  <i>...it's engrained in me, it's without a doubt who I am</i>  <i>It is who I am... I mean I really enjoy doing it because I think when you stop learning, you start dying, that's the personal philosophy of mine...</i>

**Individual interview #8.** The eighth interview was conducted with a 25-year-old Caucasian male, who has been in EMS for the past eight years. He identifies as an EMT and a firefighter. On the demographic questionnaire, he reported that he has arrived to dozens of completed suicides and identified “yes” to having personal experience with suicide.

The interview was conducted in a private conference room at a local hospital, where he is also employed. This space provided a quiet and confidential place for him to talk about his experiences. Prior to the interview, he was sent a copy of the consent form, demographic questionnaire, a recruitment letter, and a recruitment flyer, which we reviewed again prior to the start of the interview. I emphasized that participation in this study was voluntary and that he could leave the study at any time. He acknowledged voluntary participation and chose to participate. I informed him that I would be emailing him a copy of the transcription of the interview for him to review. I also let him know that I may be taking some notes throughout the interview process. I reviewed the snowball-sampling recruitment approach and informed him that if he had any names or contacts of individuals who also may be interested in participating,

that he could provide them now or via phone or email. Following the review of the materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form and he completed the demographic questionnaire. The interview lasted about 51 minutes at which the participant expressed that he did not have any other information to provide.

Prior to the start of the interview and through a brief discussion about where he is employed, he expressed that he knew people that I worked with in my position as a mental health counselor. I discussed this with him to ensure that he was comfortable with knowing mutual people, which he stated that he was fine with this, and at this time I emphasized confidentiality in the study. At this time, he informed me that he had just quit his full time job as an EMT and had been recently hired through another agency and is uncertain about whether he will continue his work as an EMT. He is also currently employed full-time at the local hospital in a position unrelated to providing emergency medical services. In addition, he was recently hired on another floor of the hospital in a PRN position. He expressed a desire to quit EMS all together, "...yeah I'm burned out." "If I have cynical answers, I apologize" he stated. He spoke about recently having a "cynical" attitude with patients and how it can be apparent at times, "A lot of people call an ambulance and it's all for attention type thing, which is, that's part of what I got burned out on really quick."

At this time, I asked about how he got into the field of EMS. He started in EMS when he got into the fire department at age 14 as a junior fireman and began riding along in ambulance trucks around age 16 or 17. He jumped to a discussion about how he has decided to get out of EMS due to personal politics, minimal income, and the town in which he works, "...the people

here are not the most desirable patients.” Participant #8 states “...a change that needed to happen.”

I asked participant #8 to describe his experiences of responding to suicide calls. He began to discuss the demographics of suicide completions, which he describes that most are middle-aged males, with self-inflicted gunshots, and family members have been more likely to find them deceased.

Usually bloody, gory. Personally I like trauma stuff and seeing that kind of stuff and I don't like seeing suicides because it's not the people that are committing suicides that have you really worry about the backlash of it. Uh, they pretty much pass their problems on and make it worse.

He dislikes arriving to completed suicides and at this time he expressed personal loss of relatives from suicide. He asked that I not transcribe the type of relationship with his relatives who passed away from suicide. At this time, I offered my condolences, and he described how personal loss “reflects over in the job. I know how that feels type of thing.”

I understand that they're in the initial shock, a lot of them, once you get there, it's “Oh did you save them?” and it's like “Obviously, no.” And that's usually one of the first things that they ask is, “Is there anything that you can do?” And most times you just shake your head and don't say anything type thing, because what can you say to those people?

He further described his role at a suicide call, which is to immediately contact the coroner as it is identified as a crime scene, make a declaration of death, and keep the family from the scene, “...no one wants to see that.” “...It's something that's burned in your memory for the rest of your life. Yeah I've personally been in that position too so it's not something that you want to...”

At this time I asked him to reflect on responding to suicide attempts. He described one particular attempt that stood out in his mind. He responded to a chaotic scene of a suicide attempt of a female who he described was acting hysterical and disruptive. She survived the attempt, but later completed suicide by hanging, “sure enough about three months later, husband comes home and she’s hanging in the barn. She did it. And uh, I responded to that one too.” I asked what this experience was like for him, “In a way since she acted like an asshole, and this is where I’ll start getting cynical, she acted like an asshole, well it’s what she wanted, so I mean...” I asked about the impact that suicides in general have had on him, where he stated:

After you get so many of them, you kind of get used to it. I don’t want to say you get numb to it, because you never exactly get over that feeling type thing, but you get more used to it.

He talked about how the youth suicides being the hardest for him to understand, which then triggered a specific memory that he recalled where children died after a man set a house on fire and killed the children and himself in the house.

And that one was a little harder to take. That one, well I would be lying if I said it was a little harder, it was a lot harder because I mean, at one point we thought we could hear the kids screaming, and there’s not a thing we could do about it.

Through our discussion, I was made aware that we lived in the same town and I recalled hearing about this event when it took place, which shook our entire town. In the moment, I attempted to focus on the participant’s responses, rather than my own emotions that I had experienced when I had previously heard about this event. He further stated, “Anyone that wants to harm kids is better off dead in my opinion.” After hearing this response, I couldn’t blame him for his statements and sensed feelings of anger from him about preventable traumatic events that

involve children. He spoke about emotional triggers of the event when he sees the mother of the children as she will occasionally present at the hospital where he is employed, "...whenever I have to see her in the \*\*\*\*, it's like, right back to square one, remembering it." I followed up with his response to ask him if his emotional response changed throughout the years with suicide calls, where he responded, "Like I said you're a little more accustomed to it, it all depends on the situation type thing." He continued the conversation by discussing additional suicide completions that he had responded to. I asked him if any issues have presented while providing EMS services in the small town he resides in and provides EMS services to. He informed me that he knew the lady he discussed earlier who had attempted suicide and then later completed suicide. He stated "...I didn't recognize her," "...after I realized who it was, I felt really bad because I mean she was a really nice lady and don't really know what was going on with her."

We reviewed all the topics we discussed and the impact that arriving to suicide completions has had on him. At this time, I asked if he had any additional information about what we had discussed thus far.

...there really isn't an answer. I've found that most of the time there's not a note. People that are going to do it are going to do it. They're not going to tell people, they're not going to just try it for the attention, they're going to do it.

I asked about self-care as an EMT and his answer was immediate, "By getting the hell out of it to be honest with ya." He spoke about difficulty understanding how people do EMS as their career. He described working between 120-140 hours per week in addition to his other job with minimal sleep.

It's not so much it was an emotional stress, I love helping people, I really do. But it got to the point where it's less helping people than it is you're a taxicab with the lights. And uh,

suicide's played a small part in that, it wasn't an overall defining uh, career ender type thing.

I asked about any professional debriefing services or other supports offered to him. He denied any use of debriefing services, "...they're supposedly [offered], but they were never like oh here. Put it on the bulletin board, call this number..." However, he spoke about peer supports with others following difficult calls. He stated he didn't believe critical incident stress debriefing or other professional support services would have been helpful for him.

Although he described a possibility of leaving EMS, I asked him how he continued to make sense of trauma and he described being a "trauma junkie." He described a preference of responding to trauma as it is much more clear-cut, as opposed to other medical calls. I asked about how he makes sense of suicide, which he described, "You really can't." "...trying to understand why someone does that is impossible." As similar to participant #1, he stated, "It's a permanent solution to a temporary problem." "Like I said, after the first couple, you just become accustomed to it..." The last question I had for him and which was unique in this interview, as he contemplating leaving EMS all together, was how he sustained his work as an EMS provider. Again he responded, "Well it's over, or very close to over anyway."

I asked if he had any additional information to add and he declined. I concluded the study and again reminded him that I would be emailing him a copy of the transcribed interview. We left the conference room together and I went to my car. Prior to my drive home, I jotted a few notes and reflected on the interview process. This interview was much different than prior interviews, as this participant was contemplating getting out of the field of EMS and had just recently quit his full-time job as an EMT. His responses were quite different than the responses I had received in prior interviews and I sensed feelings of burnout and fatigue from his responses.

The above narrative provides a review of participant #8's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #8 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements.

**Table 9. Participant #8 Supporting Statements**

Analytical Categories	Supporting Statements
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>n/a</i>
Lived space	<i>Usually bloody, gory</i>  <i>...keep the family from the scene</i>  <i>...no one wants to see that</i>  <i>...at one point we thought we could hear the kids screaming, and there's not a thing we could do about it</i>  <i>I didn't recognize her</i>
Lived time	<i>After you get so many of them, you kind of get used to it</i>  <i>It's a permanent solution to a temporary problem</i>  <i>Well it's over, or very close to over anyway [his time in EMS]</i>
Lived relationship	<i>And most times you just shake your head and don't say anything type thing, because what can you say to those people? (family members)</i>  <i>...because it's not the people that are committing suicides that you really worry about the backlash of it</i>  <i>...the people here are not the most desirable patients</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>...it's like, right back to square one, remembering it [triggers]</i>  <i>...It's something that's burned in your memory for the rest of your life</i>  <i>I don't want to say you get numb to it, because you never exactly get over that feeling type thing...</i>
Why?	<i>...trying to understand why someone does that is impossible</i>  <i>...there really isn't an answer</i>

Negative emotions/burnout	<p><i>I don't like seeing suicides</i></p> <p><i>...after I realized who it was, I felt really bad because I mean she was a really nice lady and don't really know what was going on with her</i></p> <p><i>...yeah I'm burned out</i></p> <p><i>A lot of people call an ambulance and it's all for attention type thing, which is, that's part of what I got burned out on really quick</i></p> <p><i>...suicide's played a small part in that... [getting out of EMS]</i></p> <p><i>...reflects over in the job. I know how that feels... [personal loss of suicide]</i></p>
Support services	<i>n/a</i>
Shock factor	<i>I understand that they're in the initial shock, a lot of them, once you get there...</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>By getting the hell out of it to be honest with ya</i></p> <p><i>A change that needed to happen [getting out of EMS]</i></p> <p><i>Trauma junkie</i></p>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<i>People that are going to do it are going to do it. They're not going to tell people, they're not going to just try it for the attention, they're going to do it</i>
Support system	<i>n/a</i>
Detachment	<p><i>Like I said you're a little more accustomed to it...</i></p> <p><i>In a way since she acted like an asshole, and this is where I'll start getting cynical, she acted like an asshole, well it's what she wanted...</i></p>
Acceptance	<i>n/a</i>
Family become patients	<i>n/a</i>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>...I love helping people...</i>



**Individual interview #9.** The ninth interview was conducted with a 42-year-old Caucasian male who has been in EMS for the past 22 years. He identifies as an advanced EMT and works full time in EMS. He responded “yes” to having personal experience with suicide on his demographic questionnaire and placed a question mark next to the question about how many suicide completions he has responded to.

The interview was conducted in a conference room at his place of employment. This room was private from others, although a dispatcher was in the back area of the office and we could hear calls coming in. Initially he left the door open, but prior to the interview the door was closed to provide a confidential and quiet place. He had been previously provided the consent form, demographic questionnaire, the recruitment letter, and the recruitment flyer. We took time to review these documents again prior to the interview. I made sure that he knew participation was voluntary and that he could leave at any time, which he acknowledged. I informed him that I would be emailing him a copy of the transcribed interview for him to review for accuracy. I also informed him that I may be taking notes throughout the interview process. Following the review of materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form and he completed the demographic questionnaire. The interview lasted approximately 56 minutes at which time the participant expressed that he did not have any other information to provide.

I started the interview by asking participant #9 how he got into the field of EMS. Initially he began volunteering at age 17 and then went to EMT classes offered at a local vocational school. He also reported some college experience as well. He describes working in various locations, but has been at his current position for the past 12 years. I believed our discussion about how he entered the field helped to build a rapport with the participant and therefore I asked

him to talk about his experiences with arriving to completed suicide calls. He stated that he knows what he's going into about "99% of the time," "emotionally, we're prepared for it." He provided a specific example about a guy that hung himself in his own backyard, "...I mean the family is so distraught and usually crying and balling and I really don't take that very well so I kind of like move away from the situation." He described that his role is to contact the coroner to come to the scene and how he steps back away when the coroner arrives. He discussed the process as time consuming. He provided a couple other specific examples of suicide scenes and stated that he notices themes among suicide calls, "...didn't want to make too big of a mess for my family to clean up, so they go to the bathroom thinking that's going to be the best place to clean up," specifically with self-inflicted gunshot wounds. "They're deciding to end their life and put everyone else through misery, but they're worried about the people cleaning them up." I asked about the impact on him, "...to me it's just, on aspects of emotional, suicides don't really effect me that much. Kids, now that's different situation." I asked if this impact has changed for him throughout his 22 years of experience, "Way less emotional, way, way, less emotional." "...I'm there to do a job and that's what I do." He described feeling more excited when he was new in EMS, but now stated, "...insulated from it basically." "...I've become insulated from the fact of having too many emotions one way or another." I further asked about the impact of the loved ones at the scene.

I mean, a lot... I can, I can remember a lot of the families, you, you feel for the people.

Because I don't feel for the victim, I should say. You know, he made a choice, I always figure you make a choice in your life...

He spoke about a child who saw her father being taken from a scene following an intentional self-inflicted gunshot, "I can still remember the little girl yelling, yelling out for her dad as she

you know...” “You differentiate between child and adult a lot.” He described that this man survived and that he later saw this individual when he responded to him again. I asked what his experience was like when arriving to his call for the second time, “...so it’s glad to see they made it,” “...but like I said, I don’t know what could possibly go through your mind at that time to make you do something like that.” “...suicides right below, right above heroin overdoses... you know...” At this time, I asked him about suicide attempts and what this has been like for him. “...They’re more a routine call...but the family still reacts a lot.” He talked about gunshots as more of a trauma scene because they are rare. “I think I take gunshots more seriously, simply for the fact if you’re willing to shoot yourself, then you’re willing to die.” He states that intentional overdoses/suicide attempts are much more common, “...I’ve dealt with eight OD’s just this month,” “attention grabber.” Coincidentally, as we were discussing intentional overdoses, we overheard the dispatcher in the other room receive a “suicide attempt” call. He paused for a few brief seconds and responded “See, right there, I mean, your OD’s are just routine, it’s like, oh here we go with another one.” He did describe one intentional overdose call that had an impact on him because he could connect with him at a personal level. He described this individual who was recently separated from his wife, “...you know I had actually went through that, my wife had separated you know, and I was a very emotional time for me because you don’t know how... what it is with your kid.”

I asked about any debriefing or support services offered throughout his years of experience.

That’s a tough one. I’ve been through them all, I’ve been through those debriefings because of when I worked as a correctional officer, I actually had a kid die on me in jail, he stuck morphine in and OD’d on morphine and died. So, and that being a county

organization, we had those debriefings and to me, they weren't very helpful. Nothing against your field.

He further elaborated on how he doesn't understand how someone can talk to him if they haven't been through similar experiences. He identified peer support and discussions with his partner as beneficial, "...then the humor comes out. That kind of diffuses it and then you move on to the next..." I asked if he had any additional ways of coping, which he stated, "I think it's either you're equipped to handle it or you're not equipped to handle it." I asked if he ever had any issues with living in the same areas he serviced, which he describes some sense of awkwardness when seeing them out, "...you're thinking, well let's see, she tried to OD last time and she's a cutter..."

At this time I summarized our discussion thus far and I asked how he continues to make sense of continued exposure to trauma scenes.

...it's just you know I think a lot about that. I think how your life could change, I could walk out this door and get hit you know by a car going home and that would change my life forever. And I, I think about that a lot when I'm pulling up and I see some, you see some really, and I'm not like a religious person, 'cause there was a period I didn't believe in anything basically, because of what I've seen. But uh, it just wonders because how can one person die from a slight accident and the other person survive that same kind of situation, you know?

He further elaborated, "...because you can't make sense of a chaotic system or situation, it's almost impossible..." I asked about making sense of suicides, "...to me it's just a desperate act and I don't, I don't respect.... I don't respect their decision. "...there's no respect there, that's how I deal with it basically." We explored how he makes sense of loved ones and family present

as well. “I can’t really make sense of it,” “...you get the different emotions on every scene.” “...like on the suicides especially stay separated [with family]”. “You separate it, I mean it’s separated in my mind between an accidental death and a suicide...” The last question I asked was about how he maintains his work as an EMT, “...only probably ten percent of my calls or less, probably way less than that, even that, deal with the bad stuff.” He talked about the perks of the job and how he only works a couple days per week and gets to sleep during the night shifts.

I asked if he had any additional information to add at this time based upon what we’ve talked about. He spoke about the drastic increase in mental health related calls compared to when he first started in the field, “I think some of it’s an easy way out.”

To get a medication in the system you have to have a diagnosis. Alright, first off, you ain’t really treating the problem with the medication. Two, you’re giving them a diagnosis that they fall back on to, if something happens, I walk down the street and I trip and fall, it’s because I’m depressed. Or you know, just basically something in that line.

Alright. Because you have to give a diagnosis to give a medication, but medication covers up the symptoms, but then they use the diagnosis as a crutch.

We discussed this for some bit and I heard the frustration from participant #9 about the increase in psychological calls. At this time he had no more information to add and I concluded the interview. I thanked him for the time he took to meet with me and I reminded him that I would be sending him a copy of the transcribed interview. As we concluded the interview, he began to discuss his frustrations with “mental health” in general and we reflected on this for a few moments. After this discussion, I went to my car and wrote some notes down about the interview process. I reflected upon the interview and began to notice themes/patterns. As similar to some of the participant responses, he has worked to separate and distance himself from difficult calls.

It appeared that suicide completion calls are not overly traumatic for him and he has learned to limit his interaction with family members. I noticed that our discussion was shorter than most of the interviews thus far and the above narrative had been shorter than previous narratives.

The above narrative provides a review of participant #9's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #9 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements

**Table 10. Participant #9 Quotations of Significance**

<b>Analytical Categories</b>	<b>Supporting Statements</b>
<b><i>1. FOUR LIVED EXISTENTIALS</i></b>	
Lived body	<i>n/a</i>
Lived space	<i>...didn't want to make too big of a mess for my family to clean up, so they go to the bathroom thinking that's going to be the best place to clean up</i>  <i>...you get the different emotions on every scene [from family members]</i>
Lived time	<i>...then the humor comes out. That kind of diffuses it and then you move on to the next...</i>
Lived relationship	<i>You differentiate between child and adult a lot</i>
<b><i>2. RISK FACTORS</i></b>	
Taking it home	<i>...I think about that a lot...</i>  <i>...I can remember a lot of the families</i>  <i>...you feel for the people</i>  <i>I can still remember the little girl yelling, yelling out for her dad...</i>
Why?	<i>...I don't know what could possibly go through your mind at that time to make you do something like that</i>  <i>I think I take gunshots more seriously, simply for the fact if you're willing to shoot yourself, then you're willing to die</i>
Negative emotions/burnout	<i>...to me it's just a desperate act</i>  <i>...I don't respect their decision</i>  <i>...it's like, oh here we go with another one</i>

	<i>I think some of it's an easy way out</i>
	<i>I can't really make sense of it</i>
Support services	<i>...we had those debriefings and to me, they weren't very helpful</i>
Shock factor	<i>n/a</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<i>...so it's glad to see they made it</i>  <i>I think it's either you're equipped to handle it or you're not equipped to handle it</i>
"I know the routine"	<i>...emotionally, we're prepared for it</i>  <i>...I'm there to do a job and that's what I do</i>
"You have to let it go"	<i>...because you can't make sense of a chaotic system or situation, it's almost impossible...</i>  <i>...I kind of like forget a lot of things I think</i>
Support	<i>n/a</i>
Detachment	<i>...insulated from it basically</i>  <i>...I don't feel for the victim</i>  <i>...I've become insulated from the fact of having too many emotions one way or another</i>  <i>...suicides don't really effect me that much</i>  <i>You separate it, I mean it's separated in my mind between an accidental death and a suicide...</i>  <i>Way less emotional, way, way less emotional [over time]</i>  <i>...I mean the family is so distraught and usually crying and balling and I really don't take that vey well so I kind of like move away from the situation</i>  <i>...like on the suicides especially stay separated [with family]</i>  <i>...there's no respect there, that's how I deal with it basically</i>
Acceptance	<i>n/a</i>
Family become patients	<i>n/a</i>
Their misfortune made me realize my life was pretty precious	<i>I think how your life could change...</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>n/a</i>

**Individual interview #10.** The tenth interview was conducted with a 25-year old Caucasian male who has been in EMS for the past ten years when he started in the junior fire service program. He identifies as a paramedic and firefighter. He responded “no” to having personal experience with suicide on his demographic questionnaire and identified a total of two “traumatic” suicide completions and “multiple drug induced” in the ten years he has worked in EMS.

The interview was conducted in an office at the fire station in which he volunteers. This room was private and provided a place for participant #10 to discuss his experiences. Prior to our interview, he had been provided the consent form, the demographic questionnaire, the recruitment letter, and the recruitment flyer. We took time to review these documents again prior to the interview. I made sure that he knew participation was voluntary and that he could leave at any time, which he acknowledged. I informed him that I would be emailing him a copy of the transcribed interview for him to review for accuracy. Although I had more interviews scheduled and was starting to reach saturation, I explained the snowball sampling recruitment approach and asked that if he had any names or contacts of potential participants, that he could inform me today or via phone/email. I also informed him that I may be taking notes throughout the interview process. Following the review of materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form and he completed the demographic questionnaire. The interview lasted approximately 56 minutes at which this time the participant expressed that he did not have any other information to provide.

To start the interview process and to build a rapport with participant #10, I asked how he got into the field of EMS. He spoke about joining the junior fire service program as an adolescent and found that he enjoyed the work. He took EMT classes and later became a



paramedic and has gained additional certifications with experience. He spoke about the sense of reward that he experiences in providing EMS "...they're in the worst moments of their life and for them to trust a complete stranger to come in, it's just, there's no feeling like that." After I believed a rapport was developed, I asked him about his experiences of responding to completed suicide calls. His initial response, "...I think the hardest thing is to be around the family, because you know, this is something that hits them of a sudden and you know, it's not like somebody that has an illness that you know..." He described the anger experienced by family and loved ones, "It's anger I guess not understanding the situation fully. Not understanding why they decided to hurt themselves that way," "Just watching the family because there's really no way of consoling them." He described how his role is to help family at the scene and how he has been trained in school to ask if there is anything they can do,

You have to keep yourself in a mindset that you are there to help the situation, you cannot become a part of it. You still have to remain human and have emotion, otherwise, it's time to get out or get help. But, on the same token you cannot allow yourself to become emotionally wrapped up in the situations at the time. Uh, otherwise you're becoming a part of the problem, then you are not able to think clearly enough to help the victim or the family and depending on the situation, that becomes even harder to be able to hold yourself together long enough to deal with something especially in the case of children. He further elaborated, "...you try to separate these emotions and you're trying not to become inhuman about it."

... we have to find a way to take these negative emotions, these negative feelings that we get, whether or not that we want to admit that we have them, and we have to turn that into

some form of a humor. As morbid as that might sound in some situations, that's what we have to do amongst each other to be able to overcome these things.

He described the "pride" in the field:

There's a lot of pride and we're not willing to admit when we are emotionally distraught by something because we're afraid that it's going to look like weakness to our peers and our coworkers. And a lot of times like we'll experience a bad call or we'll call in a counselor and people just aren't willing to talk to them because they don't want to look like the weak one, they want to look like the strong one, and that's kind of an unfortunate...

He started to discuss suicide among EMS personnel, which he described had occurred in the agency he works for, prior to him being employed. He mentioned that he wished more support services were offered to help EMS personnel in need, "...there needs to be something more in place to catch these things before it gets to that point..." but finds it difficult to engage in services due to the older generations in the field, "...they are truly a different generation in that they experience emotions differently, they think differently, so these things effect them differently." He spoke about how the younger generations are more open to discussion, as opposed to older generations, "...the generations before us were very close-minded to things." At this time I offered to provide him with contacts or resources of professionals that could offer support services, which he expressed his gratitude.

He began to discuss the difference in roles when arriving to suicide calls, as opposed to the need to provide emergency medical services, "I guess just trying to better understand what it is that lead to that decision." He described the difficulty with understanding why people harm themselves, "...you think back on those times and you're like, I never got to that point, but what

if I did you know...” To summarize, I asked if the impact that it’s had on him is to continuously ask himself, “Why?” and being left without any answers, which he agreed. We opened a discussion about responding to suicide attempts where he identified a similar response, wondering why individuals harm themselves. He described being a volunteer fireman and how often times his personal life gets disrupted by calls where people make poor decisions, “...it just gets really frustrating that I have to give up my time to repeatedly go back there because you chose to do the wrong thing.”

I segued the interview into a discussion about the presence of loved ones at suicides. He responded, “...you know that they’re looking at you, scrutinizing everything that you’re doing.” He described a specific scene where he arrived to a cardiac arrest where the man was deceased and how he did not feel safe with the family present due to the area of town he was in and there were no available officers to respond, “...we actually did not feel safe telling them that [he was deceased] right away.” “...there were some family members on the scene that were becoming, I wouldn’t say violent, but they were, you could feel that uneasy tension that if you did the wrong that, that it could be bad for you...” He talked about presenting care to this patient, “So what we had to do was to make it look like we tried, even though we didn’t, we knew we weren’t going to be able to do anything to help him.” He further described providing resuscitative measures and contacting the hospital and getting approval by a doctor to stop resuscitative measures. I sensed that safety has been a priority for him and in protecting his partner.

I asked him to elaborate on the impact of suicide calls, “If you’re able to leave the call, to leave our shift, and be able to say you know I feel that I did what was right with all my patients today, you can leave with a clear conscious.” He further stated, “...and a lot of times that’s not the case,” “...you sure do question yourself.” He spoke about the initial impact, “...in the very

beginning I was very naïve and I thought we're going to save everybody and we're going to save the world." "...you realize you, you know, sometimes it's not going to work." "...it gets to the point of almost instant acceptance." "...you kind of become numb to certain things." I asked if there was a time when this changed for him and he described a specific call where the chief later spoke with him:

He said... look you're not going to save everyone... I know it's hard to think that because you don't want to see anybody go through something like this, but you have to come to a certain point within yourself to, to be able to handle these kinds of things and not bring that home like that, not be upset because of something that was out of your control.

He stated "...changing your expectations to be more reasonable for those kinds of outcomes." He described having similar conversations with newer EMS now that he is in a leadership role. In addition, he spoke about the way EMS has changed him with his own interpersonal relationships.

I don't want to put myself in that situation where maybe the last thing that I say to somebody was something that really hurt them or you know, you just find you kind of... you find yourself kind of change I guess in ways, you speak to people, you deal with them, whether it be friends or family, you kind of look at things differently too... especially in this field, seeing things that we do. You might not be there you know.

At this time I asked him how he continues to make sense of responding to trauma calls in general. At this time he took a break to use the restroom and he came back and apologized in advance that his chief was now present in the station and stated, "he's not the most political correct person." I asked if he wanted to continue the interview, which he did. I asked the question again about how he made sense of continued trauma exposure. "Sometimes you do,

sometimes you don't." This prompted him to talk about a personal experience where he lost two EMS peers in a tragic car accident. As he spoke, I found myself knowing of the exact event that he was describing and I informed him that I was aware of this event. He continued to discuss this experience and the difficulty with understanding how such tragedy could happen to a family, who has been through multiple prior tragedies.

I further prompted how he makes sense of suicides, which he described a similar response, "A lot of times you really can't make sense of them," "...you cannot fully grasp what they were truly going through, is...I guess what makes that a little difficult." At this time, I asked him the last question about he sustains his work as a paramedic. "...it goes back to that feeling of being able to do something that you couldn't do in any other job... seeing things that other people don't have the privilege of seeing." He further elaborated with the following statements: "...being able to do something to help them." "...that level of pride that love and passion for what you do is a hard thing to want to give up."

I asked if he had any additional information to add and at this time he opened up about a suicide call that stood out to him. We talked about this call and concluded the interview when he no longer had any information. I thanked him for the time he took to talk about his experiences and I left the building. I wrote a few notes down in my field notes about the experience and later wrote a few additional notes. I was happy with how the interview went. I sensed this sincere desire from participant #10 to see a shift in the ways in which EMS personnel seek personal self-care and professional support. His tone of voice was soft, he appeared passionate about the work he does in EMS, and I sensed a desire to continue providing services to loved ones and family members as if they were the patients themselves.

The above narrative provides a review of participant #10's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #10 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements

**Table 11. Participant #10 Supporting Statements**

Analytical Categories	Supporting Statements
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>n/a</i>
Lived space	<i>...you know that they're looking at you, scrutinizing everything that you're doing</i>  <i>...I think the hardest thing is to be around the family</i>
Lived time	<i>...you think back on those times and you're like, I never got to that point, but what if I did you know...</i>  <i>...in the very beginning I was very naïve and I thought we're going to save everybody and we're going to save the world</i>  <i>...you get a few years into it and you realize okay, you know, sometimes, sometimes it's not going to work. Let me back that up, also in the beginning when you have that attitude, you come home at the end of every call that didn't go well and you're upset about it, because you know, you feel like you should have done something</i>
Lived relationship	<i>...they're in the worst moments of their life and for them to trust a complete stranger to come in, it's just, there's no feeling like that</i>  <i>...you find yourself kind of change I guess in ways, you speak to people, you deal with them, whether it be friends or family...</i>  <i>...because there's really no way of consoling them</i>  <i>...being able to do something to help them</i>
<b>2. RISK FACTORS</b>	
Taking it home	<i>n/a</i>
Why?	<i>Not understanding why they decided to hurt themselves that way</i>
Negative emotions/burnout	<i>It's anger I guess not understanding the situation fully</i>

	<p><i>...you cannot fully grasp what they were truly going through... I guess what makes that a little difficult</i></p> <p><i>...there's a lot of pride and we're not willing to admit when we are emotionally distraught by something</i></p> <p><i>...you sure do question yourself</i></p>
Support services	<p><i>...there needs to be something more in place to catch these things before it gets to that point [support services]</i></p> <p><i>...the generations before us were very close-minded to things</i></p> <p><i>...because we're afraid that it's going to look like weakness to our peers and our coworkers [discussing emotions with peers]</i></p> <p><i>...sometimes you just want to be able to talk to somebody and you know, you're not able to share that, necessarily, with others</i></p>
Shock factor	<i>n/a</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>You have to keep yourself in a mindset that you are there to help</i></p> <p><i>I guess just trying to better understand what it is that lead to do that decision [through conversations with family]</i></p> <p><i>You still have to remain human and have emotion, otherwise, it's time to get out or get help</i></p> <p><i>...changing your expectations to be more reasonable for those kinds of outcomes</i></p>
"I know the routine"	<i>n/a</i>
"You have to let it go"	<p><i>If you're able to leave the call, to leave our shift, and be able to say you know I feel that I did what was right with all my patients today, you can leave with a clear conscious</i></p> <p><i>A lot of times you really can't make sense of them</i></p> <p><i>...but you have to come to a certain point within yourself to, to be able to handle these kinds of things and not bring that home like that, not be upset because of something that was out of your control</i></p>
Support	<p><i>...he had brought me in and sat me down and he kind of explained that to me. He said you know, look you're not going to save everyone...</i></p> <p><i>With newer people, you really need to... and I find myself</i></p>

	<i>doing this now that I'm in a leadership role. You really need to be the one that makes sure that they're going home okay and they're not taking that with them, if you can help avoid them doing that</i>
Detachment	<i>...you cannot allow yourself to become emotionally wrapped up in the situations at the time....otherwise you're becoming a part of the problem</i>  <i>...you try to separate these emotions and you're trying not to become inhuman about it</i>  <i>...the situation, you cannot become a part of it</i>  <i>...we have to find a way to take these negative emotions, these negative feelings that we get, whether to not that we want to admit that we have them, and we have to turn that into some form of a humor</i>  <i>...you kind of become numb to certain things</i>
Acceptance	<i>...it gets to the point of almost instant acceptance</i>  <i>...finding humor in things, is maybe one of those ways of finding that acceptance I guess.</i>
Family become patients	<i>n/a</i>
Their misfortune made me realize that my life was pretty precious	<i>...you kind of look at things differently</i>  <i>...one of the things that's kind of effected with me, is how I look at my relationships with my friends and my family...what if that's the last thing that I say to you</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<i>...it goes back to that feeling of being able to do something that you couldn't do in any other job</i>  <i>...that level of pride that love and passion for what you do is a hard thing to want to give up</i>

**Individual interview #11.** The eleventh interview was conducted with a 24-year old Caucasian male who has been in voluntary EMS for the past seven years. He identifies as an EMT, volunteers part-time with a local ambulance company, and works full-time in another position with a local hospital. In addition to his EMT certification, he also has a master's degree and has hopes to enroll into a doctorate program in the near future. He responded “no” to having



personal experience with suicide on his demographic questionnaire and has responded to a total of three suicide completions in the seven years he has worked or volunteered in EMS.

The interview was conducted in a conference room after hours at his place of employment. This room was private and provided a place for participant #11 to discuss his experiences. Prior to our interview, he had been provided the consent form, the demographic questionnaire, the recruitment letter, and the recruitment flyer. We took time to review these documents again prior to the interview. I made sure that he knew participation was voluntary and that he could leave at any time, which he acknowledged. I informed him that I would be emailing him a copy of the transcribed interview for him to review for accuracy. Although I had more interviews scheduled and was starting to reach saturation, I explained the snowball sampling recruitment approach and asked that if he had any names or contacts of potential participants, to please email me. I also informed him that I may be taking notes throughout the interview process. Following the review of materials and this information, he voiced an understanding and agreed to participate. His signature was obtained on the consent form and he completed the demographic questionnaire. The interview lasted approximately 51 minutes at which time the participant expressed that he did not have any other information to provide.

To start the interview process and to build a rapport with participant #11, I asked how he got into the field of EMS. With no intention to get into the medical field, he took the EMT class with his older brothers and realized that he enjoyed the work. He stated that he didn't think he would be in his current area of employment if it weren't for EMS. We spoke a little about his role in the hospital, as he identifies as an infection control preventionist. He talked about how his current employment and work in EMS are often related. In the seven years he has been a certified EMT, he has been employed with various ambulance companies, was the EMT at the

university he attended, and he also currently works a few shifts as an EMT at the local zoo. He spoke about the current town he services in as primarily smaller and suburban.

After gaining a rapport with participant #11, I asked him to talk about his experiences with arriving to completed suicide calls. He spoke about responding to three suicide calls, two were drug related and one was a self-inflicted gunshot wound. He stated that there was a young firefighter in the community who completed suicide recently, which was difficult for his peers. He describes hearing of debriefing services following this call, but other than “normal crew debrief” with other peers, he has no experience with professional debriefing services. I segued the discussion into discussing his experiences with loved ones at the scene of suicide calls, which he informed me that loved ones were present at each of the suicide completions. At this time I asked about the impact of suicide calls or presence of loved ones:

So, like... ‘cause when I first experienced it, I thought it like, my first death in EMS, I thought it would hit me kind of harder, it was actually the one suicide, it was the older suicide, he died from the drug overdose and after that, I was like alright when do the feelings come in? Like, but I mean I was okay, I was open to anything if I was going to get emotional, I would tell someone. But, I’ve been fine throughout it all, the gunshot wound was fine, I mean I’ve had other deaths, not related to overdoses or uh, unintentional overdoses or intentional or what not. And personally I feel I’ve been fine through them all. Some of my other crewmembers I know, kind of makes them get emotional. But, uh, nothing in EMS has bothered me so far.

He spoke about the minimal emotional impact from calls in general, although he remembered a call of a child that was difficult. I asked if the impact of calls has changed for him throughout the years, “...I feel you get that desensitization throughout the years,” “...not laughing at the

situation but like you make light of situations like that..." I asked how he has coped with difficult calls or become "desensitized," "It's kind of like the opposite of those calls, that you actually save and help people because it gives you meaning." I specified about the impact of the presence of loved ones, where he initially talked about the "shock" in which loved ones have at suicides. "I don't think it's actually hit them yet," "...they were just kind of like stoic and showed no emotions." He describes a different scene at the drug overdoses, "...we actually we worked them up" which included CPR and transportation to the hospital. "...the other ones [drug overdoses] were more adrenaline rushing, we're trying to save them, we got some rhythm back occasionally, but they actually died." "...sometimes you know that they're cold, it's not going to work, but you put on a show to make the family happy that you know, you did everything," so they don't have doubts about the care provided. Initially, he denied having any other responses to suicide attempts other than the two individuals who overdosed and died, but described responding to many calls of individuals with suicidal ideations, "...I'm content with my life and then I look at my life and I'm like, how the hell are they thinking about that right now..." Through this discussion, he recalled a suicide attempt via overdose at the college he attended and worked at as an EMT. It was an individual he knew of down the hall of his dormitory. He stated that he saw this individual later on campus, "...you could tell he didn't really want to talk about it and you don't want to go up..."

At this time I asked him if there was any additional information to add about this. He added:

Um, a lot of them you can remember faces pretty vivid. Not that it bothers me, but I can always picture like what they looked like usually or where we found them and I can recall

every single thing that happened on the call, pretty well. It's not bothering, it's just I remember it pretty well.

He spoke about specific memories, "I remember the first guy, he had a glass eye that was always looking the other way." I asked if these vivid memories were with suicides or all calls, "Specifically those, other calls too I remember pretty well. Um, I remembered a lot, a lot of things pretty easily. Um, yeah, traumas or even small stuff I remember pretty well. At this time I prompted him to talk about trauma calls in general, "...you like the adrenaline, you don't like the situation..." He spoke about more chaotic scenes and distraught loved ones at the scenes. He spoke about the difficulty of transporting individuals to the hospital and not knowing the outcomes of their injuries. He talked that his current position allows for him to have some follow through with his patients, which has been nice for him. I asked if he considered suicide a trauma, which he responded, "I consider it more of a psychological," "...it's not something, something happened to them, something they did to themselves." The one individual who attempted suicide was transported to the hospital and was in the ICU, which he was able to follow through with him due to his employment, but later he passed, "...but it was interesting that I got to see him in the first job, but then a few days later here in my normal routine." At this time I asked if he had any additional information about what we have discussed thus far and he did not.

I transitioned into the last questions. First I asked about how he makes sense of continued exposure to trauma.

I mean it's something horrible that happens to someone and they call you to be there to help them and they need you right now and you just have to do the best you can, to package them up and do whatever you can on scene and get them to the hospital where they can do something more advanced.

He spoke about it being a part of who he is and how it plays in a role in his daily life. He spoke about driving down the road and seeing accidents and getting out to help those in need. I asked about how he makes sense of suicide calls:

So, trauma it's like alright package this person up, lets get going, get out of here, but with suicidal, psych calls, its more of lets talk and then you kind of have to feel it out. And it's not really what's taught in a classroom its kind of what's learned.

...and a lot of the city medics who see that all the time, the drug overdoses, kind of get worn out, they all start where I am and say well let me help you, but then through repetitive calls, they're just like oh god, it's just another drug overdose again, lets just get this person out of here. I don't see myself getting to that position. I mean, I say that now and who knows but it's been seven years and I'm still the same way, so I think the right mindset I'll be in the same position.

I asked him how he makes sense of the loved ones and family present at the scenes, "they're part of the call too, like you have to treat your patient, you have to make sure that the family members not freaking out in the corner and not there. You have to calm them down."

I mean I'm very empathetic toward anybody so I have to talk to the family, um, I can't just have them, someone crying in the corner and not do anything unless it's just like me and this other person, we have to do CPR and stuff.

"...they're as important as your patient is too." He began to describe an upcoming project that he will be doing but later asked that this information not be transcribed or used in this study. The last question I asked was how he sustained his work as an EMT, "...it just comes down to helping people when they most need it." Participant #11 stated he had no other information to provide after a summarization of our discussion. I thanked him for his time and reminded him that I

would be sending him a copy of the transcribed interview. I walked to my car and had an hour-long drive home and reflected on the interview process. When I got home I took notes to reflect on the interview. I was happy with the results of this study. His motivation to continue his education and work toward conducting research in the field of EMS was evident. He appeared dedicated to his work as an EMT and described a desire to continue his work whether through volunteer, research, or employment.

The above narrative provides a review of participant #11's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have significance. The interview with participant #11 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements

**Table 12 Participant #11 Quotations of Significance**

Analytical Categories	Supporting Statements
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>I don't think it actually hit them yet...</i>  <i>... you like the adrenaline</i>
Lived space	<i>...they were just kind of like stoic and showed no emotions</i>
Lived time	<i>...it's not really what's taught in a classroom it's kind of what's learned</i>  <i>I don't see myself getting to that position [annoyed with calls over time]</i>
Lived relationship	<i>...but you put on a show to make the family happy that you know, you did everything</i>  <i>...let's talk and then you kind of have to feel it out</i>  <i>....it's something horrible that happens to someone and they call you to be there to help them and they need you right now and you just have to do the best you can, to package them up and do whatever you can on scene and get them to the hospital [trauma in general]</i>  <i>I'm not going to judge anyone, I'm going to treat everyone the same and try to make them better. I want everyone to be better</i>

	<p><i>and get healthy</i></p> <p><i>...they've considered the ultimatum of killing themselves and it's the same exact thing, you're there at their worst time, either they or someone else called you there because their worried about them and I treat it the same, like same severity, they want to kill themselves, they're in the same danger, so... you try to do your best of talking which is not what everyone's good at usually so sometimes I get put in the place of talking to them, um... and that's interesting because none of them are ever the same</i></p> <p><i>You have to calm them down</i></p> <p><i>...I'm very empathetic toward anybody</i></p> <p><i>...it just comes down to helping people when they most need it</i></p>
<b>2. RISK FACTORS</b>	
Taking it home	<p><i>...a lot of them you can remember faces pretty vivid...</i></p> <p><i>I can always picture like what they looked like usually or where we found them and I can recall every single thing that happened on the call, pretty well. It's not bothering, it's just I remember it pretty well</i></p> <p><i>I remember the first guy, he had a glass eye that was always looking the other way</i></p>
Why?	<i>...I'm pretty content with my life and then I look at my life and I'm like, how the hell are they thinking about that right now</i>
Negative emotions/burnout	<p><i>...you don't like the situation</i></p> <p><i>...it's not something, something happened to them, something they did to themselves</i></p>
Support services	n/a
Shock factor	<i>Shock</i>
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>...I was okay</i></p> <p><i>...you make light of situations like that</i></p> <p><i>I don't see myself getting to that position</i></p>
"I know the routine"	n/a
"You have to let it go"	n/a

Support	<p><i>...it comes back, I'm putting EMS in every aspect of my life because that's like, those people are my best friends are in EMS</i></p> <p><i>My best friends on the ambulance, he's my partner and we all work together</i></p>
Detachment	<p><i>...I feel you get that desensitization throughout the years</i></p> <p><i>...I thought it would hit me kind of harder</i></p> <p><i>...I feel I've been fine through them all</i></p> <p><i>...nothing in EMS has bothered me so far</i></p>
Acceptance	<i>n/a</i>
Family become patients	<p><i>...they're part of the call too, like you have to treat your patient, you have to make sure that the family members not freaking out in the corner and not there</i></p> <p><i>...they're as important as your patient is too</i></p> <p><i>I'm very empathetic toward anybody so I have to talk to the family</i></p>
Their misfortune made me realize my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<p><i>I'm a friendly person, I'm an outgoing person</i></p> <p><i>...because I want to help them</i></p> <p><i>So it's always like the obligation to help people</i></p> <p><i>....that you actually save and help people because it gives you meaning</i></p> <p><i>But there's been a few times where I'm driving home, I'm in this type of attire [business attire], a call comes through and it's... it could be very easy, like... I'm right near by, or it can be very serious and I'll go because I want to, I'll always respond to those</i></p>

**Individual interview #12.** The final interview was conducted with a 49-year old Caucasian female, who has been in EMS for the past 11 years, and identifies as a paramedic. She responded arriving to one completed suicide on her demographic questionnaire and identified “yes” to having personal loss to suicide. The interview was conducted in a private room at her residence. There were a couple other members walking in other rooms in her house but did not



come into the area in which we were meeting. This space provided a confidential place for the interview. Prior to the interview, she was sent a copy of the consent form, demographic questionnaire, the recruitment letter, and recruitment flyer, which we reviewed again prior to the start of the interview. I emphasized that participation in this study was voluntary and that she could leave the study at any time. She acknowledged voluntary participation and chose to participate. I informed her that I would be emailing her a copy of the transcription of the interview for her to review. I also let her know that I may be taking some notes throughout the interview process. Following the review of materials and this information, she voiced an understanding and agreed to participate. Her signature was obtained on the consent form and she completed the demographic questionnaire. The interview lasted about one hour and seven minutes at which the participant expressed that she did not have any other information to provide.

After reviewing the information with participant #12, she asked me about the purpose of the study and what would happen with the results. I spent time with her discussing the purpose of the study and my hopes with the data collected, which she acknowledged. I then asked her how she got into the field of EMS, which she described a change of careers:

I'm a theater person and did a lot of theater production administration and I was actually um doing it at a theater administration job at \*\*\*\*\* and um, just started, um, becoming aware of paramedics and sort of what they do and I was looking for a change. She spoke about how the job appealed to her and found some similarity between her performance with live theater as opposed to her performance as a paramedic in life and death situations.

She described her experience working in a suburban town with minimal trauma related calls, as opposed to larger city paramedics. I started the interview by asking about her responses to suicides in the 11 years as a paramedic, "...amazingly and luckily enough, it's only been in the last few months, not long before you had sent out the notice looking for people, that I actually went on a suicide call where the person died." She then started to speak about the difficulty of providing services to patients and not hearing what happens to them after transporting them to the hospital.

Afterwards, you know, it's maybe a three-hour experience for us and then however long you keep thinking about it. But for those other people, it can be years of therapy or the rest of their lives in a nursing home or, so it's kind of, you try not to focus on that so you just go from one call to the other because you can't do anything about it.

"...There's some calls where you're like gosh I wish I knew that the person was okay." I asked about her experience with the suicide she recently responded to. She described the limited knowledge received prior to responding to the scene and when she arrived, "...daughter is on scene, she won't go near patient, says he can be violent."

When we get there, the daughter was like 17 and it was like her first or second day back at school. Um, and her father was in I guess his room which was downstairs on the bed, um and he had basically taken a box cutter and destroyed his wrists. There was just a giant hole in his, and um, I couldn't see because I didn't go on that side of the bed...but we got a call from the police can you step it up, he's you know he's in bad shape and we, which we always sort of find funny 'cause we're already going lights and sirens and there's only, you can't really, it's like, I don't know how to get here any faster, but you know if the police say that, that they are panicked...

She described her role in attempts to resuscitate this man and help to save his life. She described his “agonal breathing, ” a lot of blood loss, and her attempt with CPR. She described having minimal contact with the daughter and a neighbor who was also present. She found out that the patient had a history of psychological concerns. She continued to “work it” and transported him to the hospital, but she describes “calling it” on the way to the hospital after talking with the medical doctor at the hospital. She described a feeling of frustration with never getting answers to why this man would harm himself. She pondered whether or not this man timed his self-inflicted injuries to when he knew his daughter would arrive home from school.

But I was, I found it disturbing, it was clear that he had timed it, because he knew when his daughter was going to get home from school. He could have done it at any time during the day when he was by himself but he didn’t.

“...this 17 year old is already messed up you know, now she’s got the death, seeing her father covered in blood and you know, what’s that going to do to her? I asked what impact this experience had on her which she stated the following statements: “... ‘cause to a certain extent, you go, you see, you’re like okay this is a crisis so now I need to focus and I’m going to have a lot of people to depend on me to tell them because I’m the lead,” “if I would have been five minutes faster or something, maybe I could have helped,” “you get back in the truck, and it becomes a little bit more intimate because you have fewer people.” She further described her leadership role and the responsibility of leading the teams on the call. I redirected her on the impact that this call had on her:

...well I do think about the daughter occasionally you know, I’ll think about the daughter. And you know, you always have those moments where people are sitting around talking about calls, “Oh this bloodiest call” and if you know, it might...

occasional, it could be like, that was pretty bad call you know. But there's, you always worry you know. You know, for him it was like, he seemed like he really wanted to die, but, it's not my job to make that call. It's my job to maybe if I could get him back, maybe he'd change his mind.

I prompted her to discuss the impact, which the daughter had on her, "I do think about her" ... and she's still going through it. It's done for me," "... could they stay in the house after that? You know, how do you get up and go to school the next day or the next week?"

I asked her about her experience with suicide attempts which she described responding to many prior calls where individuals take an overdose of pills and immediately contact 9-1-1, "... it takes a lot for us to take it seriously you know." She described a sense of distancing self from it, "...you do, you have to step away from it." I asked how she disconnected, which she responded,

... And I try not to be one of those I don't care about you kind of people, but you get so focused on the procedure and the thing that you need to do to help them that you really distance yourself from the person." "...they're just an airway until you get them to the hospital.

I asked if her emotions have changed for her over the years:

Yeah, I distance more than I used to, absolutely. When I first started, I think everybody, when you first start, it's all about the helping, you want to be one of these people that people can connect, and you're supposed to connect with your patients, it makes them feel better. They trust you, they believe you when you say you need x, y, and z done. They know that you care about them and you're not just doing it as a job. You know, that you just you don't care, you just want your paycheck. It is important, you know. It's

important to help with their pain levels. And their anxiety levels, all that stuff. And so you try, but then when you're really doing the stuff you're, you can't, you got to do x, y, z, you know.

At this time I asked about any debriefing or support services that she has engaged in, "...I've never found the sort of formal stuff that's out there particularly useful."

...nobody wants to get vulnerable in front of their colleagues, particularly the police and fire. You don't want to be the person who's crying because even though they probably would be very sympathetic, they still remember you're the one that was vulnerable the next time you go on a big incident."

...you don't want the people you're about to go on another call with to think, are they going to fall apart or extremely weak?" She described that many people know if you are seeking help and often times it becomes "awkward" and she spoke about a desire to see a more anonymous way of seeking our professional services. What she finds more useful is peer support. I asked about any additional ways in which she self-cares:

The ones that bother me I just go over them in my head again and again and again and again. Um, you know, it's hard to remember that no matter how many times you step through it, you can't actually change it at that point you know. It's not like other things...

She also described coming home and hanging out with the kids and how the separation from work and home is a form of self-care. I asked her if she had any additional information on the impact among suicide calls, which she declined. At this time I asked her about how she makes sense of her continued exposure to trauma scenes, "...we do it because at the end of the day we know we're helping someone, at a moment of crisis. And so it's good to keep that in mind, that

you're actually helping people," " ...there's always a, challenges, so far it's never become boring." I further asked how she makes sense of suicide calls:

... you can get very judgmental and we do... we do. Um, so I think to some extent you just have to, you have to let it go, um, we're never going to know the answers to the why's. You know, we have to not take it personal and let it go and go do, go do the job, and go to, with the person that we can help.

Lastly I asked participant #12 how she maintains her work as a paramedic:

you definitely have to not take it personally, um because, um, you can't, you cannot be a person and unfortunately I'm not this kind of person so I have to keep reminding myself this much, you can't be a person who needs validation from anybody else.

She also stated, "If you let yourself get bored or burned out, then it's time to move on."

Because it's not... it's not the bad calls like the suicide, it's not those calls that make it difficult, it's the calls where you think where, where I could have done a better job and the patient is no better off, but they could have been.

At this time the interview concluded and I asked if she had any additional information that she wanted to share, which she declined. I thanked her for the time she took with me to talk about her experiences and I reminded her that I would be sending her a copy of the transcribed interview. I had an hour-long drive home, which I spent reflecting on the interview. This interview was different than others, as she had only responded to one completed suicide call as opposed to multiple suicide completions. We had the opportunity to spend a majority of our time discussing her experiences with this specific call and I was happy with how the interview went.

The above narrative provides a review of participant #12's descriptions of the phenomenon being studied. Some information was not included in the narrative if it did not have

significance. The interview with participant #12 provided supporting statements that were directly related to the analytical categories. The following table categorizes these statements

**Table 13. Participant #12 Quotations of Significance**

Analytical Categories	Supporting Statements
<b>1. FOUR LIVED EXISTENTIALS</b>	
Lived body	<i>n/a</i>
Lived space	<p><i>...so now I need to focus</i></p> <p><i>...you behave differently if they're in the room [family]</i></p> <p><i>...I'm going to have a lot of people to depend on me to tell them because I'm the lead</i></p> <p><i>...you get back in the truck, and it becomes a little bit more intimate because you have fewer people</i></p> <p><i>It's not like other things...</i></p>
Lived time	<i>...when you first start, it's all about the helping,...</i>
Lived relationship	<p><i>...you're supposed to connect with your patients, it makes them feel better</i></p> <p><i>...you never want them to ever go away thinking you were disrespectful to their loved one</i></p> <p><i>They know that you care about them and you're not just doing it as a job</i></p>
<b>2. RISK FACTORS</b>	
Taking it home	<p><i>...if I would have been five minutes faster or something, maybe I could have helped</i></p> <p><i>...it's hard to remember that no matter how many times you step through it, you can't actually change it at that point...</i></p> <p><i>The ones that bother me, I just go over them in my head again and again and again and again</i></p> <p><i>...well I do think about the daughter occasionally</i></p> <p><i>I do think about her</i></p> <p><i>...There's some calls where you're like gosh I wish I knew that the person was okay</i></p>
Why?	<i>...maybe if I could get him back, maybe he'd change his mind</i>

Negative emotions/burnout	<p><i>If you let yourself get bored or burned out, then it's time to move on</i></p> <p><i>...this guy may or may not actually wanted to die even though he had done serious damage to his self</i></p> <p><i>Because it's still stressful and your mind goes into that panic mode, particularly if things aren't going well and you're like oh I totally... you can freeze up and what should I be doing next. What if I screwed up, what if I forgotten...</i></p> <p><i>...you can get very judgmental and we do</i></p> <p><i>...it's very easy in EMS to get very jaded and to get hard, and to get judgmental...</i></p> <p><i>It takes a lot for us to take it seriously you know</i></p> <p><i>...I found it disturbing</i></p> <p><i>...you always worry</i></p> <p><i>...you don't really get paid a huge amount of money</i></p> <p><i>...the job doesn't feel super satisfied</i></p>
Support services	<p><i>...you can't be a person who needs validation from anybody else</i></p> <p><i>...I've never found the sort of formal stuff that's out there particularly useful</i></p> <p><i>...nobody wants to get vulnerable in front of their colleagues</i></p> <p><i>...they still remember you're the one that was vulnerable the next time you go on a big incident</i></p> <p><i>...there's a lot of times when you do not feel appreciated</i></p>
Shock factor	n/a
<b>3. PROTECTIVE FACTORS</b>	
Personal characteristics	<p><i>...so far it's never become boring</i></p> <p><i>...you have to be very internally strong</i></p> <p><i>...you have to have something else [another interest]</i></p>
"I know the routine"	n/a
"You have to let it go"	<p><i>...to some extent you just have to, you have to let it go...</i></p> <p><i>...take off my uniform and not think about it</i></p>
Support	<i>...hanging out with the kids is a good one</i>



Detachment	<p><i>...you have to step away from it</i></p> <p><i>...their just an airway until you get them to the hospital</i></p> <p><i>Disconnect</i></p> <p><i>...I distance more than I used to</i></p> <p><i>...you try not to focus on that so you just go from one call to the other because you can't do anything about it</i></p> <p><i>...you get so focused on the procedure and the thing that you need to do to help them that you really distance yourself from the person</i></p> <p><i>I think you need that separation</i></p> <p><i>...I think separating for work, definitely helps as well</i></p>
Acceptance	<i>n/a</i>
Family become patients	<i>n/a</i>
Their misfortune made me realize that my life was pretty precious	<i>n/a</i>
<b>4. MEANING OF EXPERIENCES</b>	
What I get from the work	<p><i>...we do it because at the end of the day we know we're helping someone</i></p> <p><i>...it can be rewarding in a weird way</i></p> <p><i>...you're actually helping people</i></p>

### **Cross-Case Analysis**

The twelve participants in the individual interviews verbalized many similarities as they described the experiences of responding to completed suicides where loved ones of the deceased were present. However, not all of the analytical categories were represented in each individual interview. Table 14 provides a cross-case analysis of the supporting statements from each analytical category between all of the individual interviews.

Table 14. Cross-Case Analysis

Analytic Category	Int. 1	Int. 2	Int. 3	Int. 4	Int. 5	Int. 6	Int. 7	Int. 8	Int. 9	Int. 10	Int. 11	Int.12
<b>VAN MANEN EXISTENTIALS</b>												
Body	x	x	x	x			x				x	
Space	x	x	x	x	x	x	x	x	x	x	x	x
Time	x	x		x	x	x	x	x	x	x	x	x
Relationship	x	x	x	x	x	x	x	x	x	x	x	x
<b>RISK FACTORS</b>												
Taking it home		x	x	x			x	x	x		x	x
Why?	x	x	x	x	x	x		x	x	x	x	x
Negative emotions/burnout	x	x		x	x	x	x	x	x	x	x	x
Support services		x		x			x		x	x		x
Shock factor	x	x		x		x	x	x			x	
<b>PROTECTIVE FACTORS</b>												
Personal Characteristics	x	x	x	x	x	x	x	x	x	x	x	x
“I know the routine”	x	x							x			
“You have to let it go”	x	x	x	x	x	x	x	x	x	x		x
Support		x	x	x	x	x	x			x	x	x
Dehumanization/ detachment	x	x		x	x	x	x	x	x	x	x	x
Acceptance		x		x			x			x		
Family become patients		x	x	x		x	x				x	
Their misfortune made me realize my life was pretty precious			x						x	x		
<b>MEANING OF EXPERIENCES</b>												
What I get from the work	x	x	x	x	x	x	x	x		x	x	x

The above table shows the emerging themes found among the individual interviews, which is further discussed in the following chapter. All of the individual interviews included personal experiences of responding to completed suicides and the presence of loved ones of the deceased at the scene. Included are narratives of each interview among which participants described the impact of direct and vicarious traumatization. I expected that the impact of responding to suicide completions and having loved ones present at the scene would vary among paramedics and EMT's because of the various ways in which my clients' cope with direct traumatization and how myself and other counselors are impacted by vicarious traumatization.

All of the interviews provided descriptions of self-care in EMS and specific details emerged about what triggers an emotional impact for some. What was of interest was how those with personal loss to suicide have been impacted in the ways they provide emergency medical services to their patients and loved ones and how they have changed when arriving to completed suicide scenes or suicide attempts. I was surprised to learn that seven of the 12 participants had responded "yes" to having personal loss to suicide themselves.

Finally, all participants expressed protective and risk factors in their work in EMS. Most of the participants identified personal characteristics, support systems, an ability to maintain boundaries with work and their personal life, and routine care as protective factors. Additionally, risk factors such as negative emotions, burnout, minimal coping and support, questioning and wondering why individuals engage in harm to self, taking work home, and shock in arriving to suicide scenes, were identified.

Some substantial differences were identified in the ways the participants described their experiences with direct and vicarious traumatization at suicide completions. The significant difference found in the data collected was with one participant who recently quit his full-time job

as an EMT due to feelings of burnout and negative emotions associated with his work. A majority of participants described a minimal impact in responding to completed suicide scenes where loved ones of the deceased were present and even found satisfaction in their work. Several other topics were not expressed in all interviews, such as supervisory support and vivid memories of scenes, while other statements were consistent between interviews. The supporting statements in the cross-case analysis have been used to develop central themes that are further discussed in the following chapter.

### **Summary**

This chapter provides an overview of the data explicated from all twelve individual interviews. Narrative descriptions of each individual interview provide supporting statements from participants that relate to the theoretical frameworks and identified themes. In addition, my own field notes and analytics notes are included in the narratives. Tables are used to organize the supporting statements that correspond to the analytical categories when applicable. The chapter concludes with a cross-case analysis of the supporting statements within the analytical categories. This data was used to construct the main themes that are elaborated in the following chapter. A further explication of the main themes is presented in Chapter five.

## **CHAPTER V: DISCUSSION**

### **Introduction**

The preceding chapters constitute an inquiry into the lived experiences of paramedics and EMT's who have responded to completed suicides with the presence of loved ones of the deceased at the scene. A review of the problem, background, and rationale was provided in earlier chapters to enhance the understanding of the work that paramedics and EMT's engage in during their daily duties of providing emergency medical services. The research question and a review of the literature were presented, and the methodology for this study was described. The data was collected and explicated accordingly. Lastly, this chapter seeks to further explore the themes that emerged in this qualitative study.

In the field of emergency medical services, there is a vast amount of literature that indicates that continued exposure to trauma can result in a psychological impact among workers (Benedek, et al., 2007; Briere & Scott, 2013; Regehr, et al., 2002; Ussery & Waters, 2006; Williams, et al., 2008). Although the literature has focused on the direct trauma that EMS personnel experience when responding to traumatic events, the secondary traumatization that can be experienced when EMS personnel experience the events through the eyes of family and loved ones at these traumatic scenes must also be considered. The awareness of the psychological impact through the literature has resulted in the development of treatment interventions for EMS personnel, such as critical incident stress debriefing services.

Most recently, what has gained attention by researchers is the PTG that some individuals experience following traumatic exposure (Park, et al., 1996; Tedeschi & Calhoun, 1995). In fact, some of the research suggests that far more people experience growth from traumatic exposure than those who experience a negative psychological impact that meets the criteria for a

psychiatric diagnosis (Tedeschi & Calhoun, 1994). A look at EMS resiliency and PTG has recently been examined by researchers and suggests that positive changes are experienced by many EMS personnel, such as a sense of personal strength, new appreciation for life and interpersonal relationships, and exploring new possibilities in one's life (Shakespeare-Finch, et al., 2003). The literature that has looked at PTG among EMS personnel has focused on their direct exposure to traumatic events. There has been little attention given to the PTG from vicarious exposure for EMS personnel. Additionally, the experiences among EMS personnel when responding to mental disturbance calls, specifically completed suicides, have also been overlooked.

The focus of this study was to explore the lived experiences of paramedics and EMT's who responded to completed suicides with the presence of loved ones of the deceased at the scene. EMS personnel who participated in this study identified unique experiences with multifaceted traumatization. Although participants described various descriptions of multifaceted traumatization, their stories revealed both positive and negative experiences in responding to calls of completed suicides. Some of the positive experiences expressed by participants included personal growth, increased sympathy to patients and their families, increased value in their life, and the reward of helping others. Some participants also described negative emotions or risk factors from their experiences with multifaceted traumatization, such as feelings of burnout, lack of closure, poor support services, and characteristics of vicarious traumatization.

This chapter provides a review of the themes that emerged from the data using van Manen's (1990) hermeneutic phenomenological theoretical approach. Each theme illuminates the experience related to the research question. The chapter concludes with a review of the

limitations of the study, questions that were generated from the study, and suggestions for future research.

### **Discussion of the Findings**

The themes that emerged from the narratives were derived through semi-structured interviews with twelve willing participants. Chapter IV identified the themes that emerged and the following chapter provides a more thorough explication as these themes provide insight into the lived experiences of the participants in this study. In this section, the themes are presented and discussed in response to the research questions.

#### **Research Question #1**

The theoretical foundation for this study was van Manen's (1999) four lived existentials which informed the question, "How do paramedics and emergency medical technicians experience responding to completed suicides where the loved ones of the deceased are present?" The interview data from this study aligned with van Manen's (1999) four life world existentials (lived body, lived space, lived time, and lived relationship).

**Theme #1. Corporeality.** Six of the participants in the study spoke of lived body in their work in EMS. Although some of the descriptions of lived body were positive, others verbalized negative physiological reactions at completed suicide scenes. Four of the participants described an "adrenaline rush" as their emotional reaction experienced when arriving to traumatic scenes, such as calls of attempted suicides that may or may not have resulted in death. This sense of adrenaline from responding to traumatic events appeared to be one of the qualities that initially attracted participants to EMS and helps to maintain their interest. Although the adrenaline rush appeared to be a protective factor for some traumatic calls, participant #3 indicated, "We all cringe at the thought of having to go on a suicide." Suicide completions were described as much

different than other traumatic calls, such as attempted suicides. The scenes are calmer and less anxiety provoking, although described as undesirable. Two of the participants spoke about the importance of allowing oneself to calm down following a rush of adrenaline and even completed suicides. Statements such as “take it all in,” “digest everything,” and “feel yourself calming down,” appeared to be ways to come down from those high intensity moments. It appears that allowing oneself to calm down is a form of self-care among EMS personnel and essential in maintaining their work with exposure to trauma.

Three of the participants described lived body as the gruesome interactions with their patients at scenes of attempted and completed suicides. Phrases such as “there was brain matter, I had it all over my shirt” and “we had to hold his tongue out.” These experiences described by participants that relate to the corporality seem to indicate that participants not only experience their own physiological reactions, but also through witnessing the visual images, and experiencing the physical interactions through touch with their patients. Although EMS personnel typically require touch to various body parts of their patients through providing emergency medical services, these experiences appeared to negatively impact the participants, as one participant indicated that he had to remind himself to “focus, focus, focus.” It appears that these images and interactions can be a distraction with the task at hand, which could ultimately lead to a higher adrenaline rush or stress reaction and ultimately lead to ineffectiveness on the job. It was evident that gaining experience in EMS resulted in an improved ability to focus and provide effective medical interventions at difficult and traumatic scenes.

**Theme #2. Spatiality.** The lived space that was expressed by the participants was typically a description of the environment and the physical surroundings at completed suicides and how they experienced it. Three of the participants described the scenes at a completed



suicide as much different than other types of traumatic scenes. They spoke about the mood or atmosphere at the scene, “There’s a sense of calmness,” “subdued,” “somber,” as opposed to what they experience in other traumatic scenes. Their normal and everyday role is to provide emergency medical services, but at a completed suicide call, there are no medical interventions to provide. Rather, their roles shift to caring for family members and contacting the appropriate authority. While waiting for others to arrive, there is an opportunity to talk with loved ones at the scene and provide support. This change in roles described by these participants appears to be a much different experience for EMS personnel and has been described as “easier” for some. This “easier” role suggests a less anxiety provoking role and less pressure due to the minimal amount of interventions being provided. Additionally, there is an opportunity to provide support to loved ones, which also appears to be a protective factor, and is further discussed below.

Two of the participants described completed suicides differently, indicating that completed suicides can be more chaotic. Statements such as “usually bloody, gory,” “the room was still full of smoke...” and “Trying not to pay attention that I’m kneeling on trash and needles.” It appeared that these two individuals focused more on the visual images at the scene, such as the damage that was done to the body, rather than focusing on providing support to loved ones or making appropriate calls. Ultimately, these images affected their ability to function effectively on the job. One participant who described the difficulty with the visual images is currently getting out of his job in EMS and mentioned that responding to suicide calls did have a small part in getting out of the field. His experience indicates that an inability to look past the visual images can lead to leaving the work. The other participant described coming a long way in learning to cope with completed suicide scenes, as the statements she made were from her first response to a completed suicide. It appeared that if EMS personnel are able to overcome the first

completed suicide, they will be able to respond effectively to future suicides and learn their role at that type of scene. Additionally, it is evident that an ability to learn coping mechanisms and having support are essential to coping with future suicides.

**Theme #3. Temporality.** Lived time revealed that time is truly of the essence in EMS. EMS personnel seemed to describe an emotional “learning curve” whereby individuals develop a greater ability to cope with the traumatic exposure of their work better over time. The participants identified time as crucial to managing one’s emotions with continued traumatic exposure. They used statements such as “I think it’s not as hard now,” “my heart rate doesn’t increase [anymore],” and “after you get so many of them, you kind of get used to it.” Participants emphasized that early on in their careers they experienced more of an emotional response to providing EMS services and arriving to completed suicide scenes, but as time has gone by their ability to detach improves and they experience less of a physiological response. It appears that time is crucial in EMS and can help to establish boundaries, learn to detach, and improve coping abilities.

Participants also described time as crucial when responding to a suicide attempt, as opposed to a completed suicide. At a suicide attempt, the role shifts back to what they are trained to do which is to provide emergency medical services and transport the individual to the hospital, “When I still have them and I’m working them, there’s hope.” This role is described as “routine” and much different than arriving to a completed suicide, where their role is solely to contact appropriate authority and provide support to the family. Participants also described a concern for patients following their suicide attempt, “...the ones that scare me the most, this isn’t going to be the last time I see you...” and “you’ll get the same person who will threaten suicide over, and over.” Although participant #1 indicated that every suicide attempt is taken seriously, participant

#8 indicated symptoms of burnout from responding to individuals who repeatedly attempt suicide. These individuals seemed to identify risk factors in repeated response to the same individuals who attempt suicide. It appeared that these individuals become “annoyed” with “frequent callers” following suicide attempts and that participant #8’s response indicated that this can lead to symptoms of burnout among EMS personnel.

Lastly, some participants described lived time as a process of waiting for the appropriate authority to arrive at a completed suicide call. Participant #1 described waiting in his ambulance truck and playing on Facebook until the coroner arrives, which can take up to an hour or two. This participant has many years in EMS and had expressed an ability to detach from his work. However, he stated that when family or loved ones are present, he will wait with them and provide support and review procedures with them. Another participant described his role as a grief counselor to the loved ones during the time he waits for additional authority to arrive. Further, participants expressed that they never leave a family member or loved one alone at a completed suicide scene, rather they ensure that other family or support have arrived before they leave the scene. While some participants focused primarily on the family at these scenes, paramedic #9 described a preference to remain distant from family and loved ones while waiting for the authority to arrive, “...don’t take that very well so I kind of like move away from the situation.”

Time in a larger sense seems to provide a protective factor with the development of coping skills and an ability to detach from or harden to the trauma of others. It seems as if the actual time on scene is almost an intermission from their regular tasks. They wait for other authority and they stand in as supports until other support arrives. They are almost like placeholders for others who come and pick up the work of support and finishing the details. This role

may provide a protective factor for EMS personnel, as there appears to be less responsibility at a completed suicide scene and more emphasis on waiting and providing support to loved ones. However, the one participant who described a preference to remain distant from the loved ones indicates that presence around family during their initial grief may effect their ability to function effectively.

**Theme #4. Relationality.** From participant's responses, it was clear that relationships are essential in providing emergency medical services. Relationships were spoke of from multiple perspectives, including the relationships with patients, the relationships with family and loved ones of the deceased, and the relationships with other EMS personnel, which is further discussed under the theme, Support. Most of the participants described a sense of empathy toward their patients who have attempted or completed suicide. Phrases such as "I'm not going to judge anyone, I'm going to treat everyone the same and try to make them better" and "I'm very empathetic toward anybody." These statements indicate that some people may judge patients for attempting or completing suicide based upon the stereotypes that exist with "psych" patients or mental disturbance calls. However, participant's responses indicate that by having an ability to push aside negative or judgmental thoughts, they are able to provide the appropriate support to the loved ones in their time of initial grief.

Participants described the relationships with the loved ones of the deceased as an essential part of providing EMS. Phrases such as "that's why I won't judge anybody else because it's somebody's family member," "I've always been about the family," and "being able to do something to help them." Although participants reported that they're trained to provide support services to family, some of them indicated that they go the extra step in caring for the family members. It is interesting to note that many of the participants that expressed having empathy

toward their patients were those who described having personal loss to suicide themselves. These individuals seemed to have an understanding of what it means to be a loved one of the deceased and can relate to their experiences. As mentioned above, EMS personnel's standard role of providing emergency medical services changes at a completed suicide call, but by providing support to loved ones, they can still provide a service to their "patients" in a sense. This relationship with the loved ones of the deceased also appears to be a protective factor for some participants as it gives them a greater sense of meaning or purpose at the scene.

**Implications.** Van Manen's (1999) life world existentials help to ground the "lived experiences" described by participants in this study. The work that EMS personnel do in their daily routine is expressed by participants in ways in which readers can gain knowledge and understanding of their "life world." By exploring the descriptions of their "lived experiences," the work in EMS can be understood as more than just providing emergency medical services and transportation to the hospital.

When the research is examined among EMS personnel and their experiences with traumatic exposure, we can see that some of the literature supports participant's life world experiences. The literature indicates that continued traumatic exposure among EMS personnel can result in negative psychological effects among some (Regehr, 2005; Williams, et al., 2008) and this notion is further discussed below under the theme of risk factors. Through the responses that highlighted participant's view of their "lived world," some emphasized negative reactions or emotions through their experiences, such as the visual images at a completed or attempted suicide scene or the interactions with patients or the deceased. It appeared that these factors have contributed to difficult emotions for participants and even described as symptoms of burnout among one participant who has decided to recently leave the field of EMS. The literature

indicates that burnout is described as “a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work” (Maslach, 2003, p. 2). However, most of the participants described an ability to cope with these negative emotions with experience over time, which is also revealed through the literature (Bonanno, 2004).

The “learning curve” in EMS appears to be a fundamental tool in coping with multifaceted traumatization and sustaining work in EMS. Many participants expressed the initial difficulties early on in their careers with responding to traumatic events such as completed suicides, however with experience and time, an ability to detach from their work and maintain emotional stability was described. All but one participant described an ability to sustain their work in EMS and identified ways in which they have coped over time with responding to completed suicides and working with the family and loved ones at the scene.

Typically, “trauma” drives many individuals into the field of EMS as the hype and adrenaline of helping others in emergency situations gives them meaning and gratification. In this study, it appeared that some of the participant’s indicated that some traumatic scenes, such as completed suicides, do not give them a sense of fulfillment of helping others or saving lives. Rather, the scene is described as much different than other traumatic scenes, more “quiet” and “calm.” However, they described a shift in their roles and gaining satisfaction by helping the loved ones at the scene. Their role is to contact appropriate authority, ensure that other supports are available, and provide comfort and support to the loved ones. The connection between the paramedic or EMT and the loved one was noted throughout the interviews and highlights van Manen’s (1990) lived existential of relationality.

## **Research Question #2**

As the literature indicates, risk factors have been identified among EMS personnel and their experiences with continuous traumatic exposure. The second research question for this study was, “What risk factors are associated with EMS personnel as they respond to suicides where loved ones of the deceased are present?” The essence of this question was to identify what risks factors are associated with traumatic exposure, specifically when experiencing direct and vicarious exposure of responding to completed suicide calls with the presence of loved ones of the deceased. Although the third research question which identifies protective factors of work in EMS appears more significant in this data, multiple risk factors were identified that relate to the definition of burnout and vicarious traumatization.

**Theme #5. Taking it home.** Although more protective factors were expressed by participants and are discussed below in a review of the third research question, risk factors in providing EMS were also identified by participants. Eight of the participants expressed times where establishing boundaries became difficult and they left work and reflected on the scenes or calls they had been on. Phrases such as “trust me, you think about it,” “I think about that a lot,” and, “ I can always picture like what they looked like usually or where we found them and I can recall every single thing that happened on the call.” These statements indicate that EMS personnel have calls of completed suicides that they later think about and carry with them. Some described the emotional impact that reflecting on these types of calls have had on them, “Lots of times there’s sleepless nights,” “...if I sit here and told you that I didn’t have nightmares about some of the stuff, I would be lying,” “it’s something that’s burned in your memory for the rest of your life,” and one participant indicated that if he took work home with him “I wouldn’t have a family and be divorced and living alone, probably be an alcoholic or something.” There seemed

to be a recognition among the participants that the work held the potential to carry over into their personal lives. Their reports of ruminating upon specific calls and holding detailed memories of past calls, indicates that the work can have long lasting psychological impacts upon even the most seasoned EMS. It is interesting to note that many of the participants that expressed recurring negative thoughts were those that had a long career as EMS personnel. These individuals seem to have an ability to experience these symptoms of vicarious traumatizing, yet continue in their work, most with reported satisfaction. There also seemed to be an awareness that finding ways to compartmentalize such thoughts, “But, you compartmentalize it and it just kind of, you just kind of shoot away into a special place in your brain I guess,” and an ability to push those thoughts away is essential to continuing the work. One participant discussed wanting to change careers due to the difficulty in separating his emotions from his work. His experience indicates that an inability to find effective ways to cope with traumatic exposure can lead to an inability to continue the work.

Participants also expressed concern for family members of the deceased, “I can remember a lot of the families” and “I can still remember the little girl yelling, yelling out for her dad,” and “well I do think about the daughter occasionally.” Although some participants described ways to separate [emotionally and physically] from family members, it appeared that any scene with children made it more challenging to forget or detach from and were particularly disturbing. One participant expressed concern for the daughter of the deceased who was present at the scene that day, describing that although the event would end for her that day as the paramedic on call, it was just the beginning of grief for her. The research has described the emotional impact as very difficult for children who have lost a loved one to suicide. An article by Mitchell, et al., (2004) suggested that children whose parents die by suicide are more likely to



have symptoms of “complicated grief” (Mitchell, et al., 2004). Complicated grief is defined as the significant reaction that loved ones experience from the loss of a loved one to suicide (Bailey, et al., 1999; Mitchell, et al., 2005). There seemed to be a sense of complicated grief for participants themselves, as their reports of questioning why someone would choose to end their life, indicated a lack of understanding or a limited sense of closure. Therefore, if as an adult who more than likely does not have a significant relationship with the deceased and is only providing EMS can experience this type of grief, I can’t imagine the children who are experiencing the loss of a parent or loved one to suicide. There appeared to be feelings of anger and resentment among participants, that somebody could be so selfish to leave their children behind to experience such a loss that could have been prevented. The statements made by these participants indicate that their sense of sorrow for the children do reflect into their personal lives when they leave the job to go home.

**Theme #6. Why?** The participants spoke about leaving the scene of a completed suicide and wondering “why” an individual would choose to harm themselves. Five of the participants wondered how somebody could come to a point in their lives where they felt the only option was to take their own life. Statements made by participants included, “but eventually you’re like, why? What happened? Like, what happened behind the scenes that nobody knows about. What caused it?” “I don’t know what could possibly go through your mind at that time to make you do something like that,” and “not understanding why they decided to hurt themselves that way.” Participant #3 also questioned why somebody would harm themselves, but stated “I can sit here and say that nothing would ever drive me to wanting to kill myself, but I’ve never been pushed that far.” There appeared to be a sense of lack of closure as participants spoke about their inability to understand why others choose to harm themselves. I sensed that this lack of closure

was difficult for some of the participants and impacted their ability to cope with the uncertainty. There appears to be a need for information from loved ones about the suicide to help them understand the deceased and perhaps, themselves in the work. Their experience of caring and supporting the loved ones of the deceased seem to make it important to find an understanding of the act itself. Despite their attempts to gain information about their patients by speaking with loved ones, they truly never gain a sense of closure in understanding why their patient chose to harm themselves.

**Theme #7. Negative emotions/burnout.** Although the next research question identifies protective factors in reducing the risk of a psychological impact among participants in this study, all twelve participants revealed negative emotions with multifaceted traumatization in responding to completed suicide calls. As the literature indicates, there is a risk of developing psychological disorders in EMS such as depressive disorders, anxiety disorders, personality disorders, psychotic disorders, and substance related disorders (Briere & Scott, 2013). Some participants in this study endorsed symptoms related to these disorders. As previously discussed above under theme #5, allowing themselves to take the work home was identified as a potential risk factor for deleterious effects of traumatic exposure, and this section reviews additional negative emotions and symptoms of vicarious traumatization.

Negative emotions identified in the participant interviews included symptoms of anxiety, depression, anger, sorrow, disturbance, lack of understanding, and burnout. A common pattern among participants in this study were feelings of anxiety and depression when responding to suicide calls. Phrases that indicated this included, “anxiety provoking,” “you always worry,” “if I think about the last ten suicides that I saw, you’re just going to be depressed.” Anger is often associated with symptoms of depression and was noted by some of the participants in this study,

“You get mad at them” and one described feeling “angry.” In fact, some even described feelings of disrespect regarding the individual’s decision to take their own life, “I don’t respect their decision” and “it’s not something, something happened to them, something they did to themselves.” The scenes at a completed suicide call can be disturbing, “I found it disturbing,” “I don’t like seeing suicides,” and “you don’t like the situation.” This end-all decision makes it difficult to understand for some, “it’s senseless that they tried this whether it was completed or not,” “I can’t really make sense of it,” and “you cannot fully grasp what they were truly going through...” Feelings of sorrow were also common, “I feel bad that you’re at this point in your life where you think this is the only answer.” Lastly, some participants described a sense of burnout when responding to suicide calls, “how can I keep facing this” or mentioned that detachment was integral part of EMS, “if you let every one of them bug you, you’re going to be in this job a year and will be done. Burnout.” Despite the negative emotions described by all twelve participants, only one participant truly reported feeling burned out in the job and had recently quit his full time job in EMS, “Yeah I’m burned out” and further stated “suicide’s played a small part in that.” As I looked back into chapter two of the literature review, I reviewed the literature on burnout. The literature suggests that there are few correlations found between symptoms of burnout and demographic characteristics. Some of these characteristics included those under the age of 30, unmarried, and who have high expectations in their job (Maslach, et al., 2002). The individual who identified feeling burned out was 25 years old, had eight years in EMS, had mentioned that he has never been married, and had responded to “dozens” of completed suicides. During the interview he had described having expectations that were not met in his job in EMS, which included a desire to have a higher pay and more respect from management. It may be that these factors played a role in his feelings of burnout. However, two

other participants were also males, under the age of 30, and were unmarried, but did not identify feeling a sense of burnout in their work. What is clear is that the burden of seeing individuals whose lives have lead them to a place of such despair takes a toll on the workers who respond to these scenes. Their personal experience of direct traumatization can lead to symptoms of burnout and vicarious traumatization. When you couple this direct experience of trauma with coping with needing to care-give to the loved ones, it can result in symptoms of burnout and other negative emotions that can result in EMS personnel choosing to leave the field of EMS. However, with support systems, coping mechanisms, and meaning found in their work, a majority of them continue to sustain their work in EMS and find satisfaction in helping others.

**Theme #8. Support services.** Another risk factor that presented among the data was participants' views of professional critical incident stress debriefing services. Five of the participants described negative thoughts about professional debriefing services, indicating that it was ineffective or did more harm than good, which is also reported in the literature (Addis & Stephens, 2008; Prati & Pietrantonio, 2010; Small, et al., 2000). Statements made by participants that described these negative views of professional debriefing included, "I thought it did more harm than good...because they wanted to force you to talk about it and if I don't know you I'm not opening up to you," "it opens the, keeps the wound open too much," and "we had those debriefings and to me, they weren't very helpful." Participant #10 also believed that being "vulnerable" in front of their colleagues could be seen as weakness "look like weakness to our peers..." which is similar to some of the research conducted on first responders and debriefing services (Koch, 2010). Most (seven) of the participant's preferred to have casual conversations about difficult calls with their peers, rather than engaging in professional debriefing services or taking conversations home with their families. It appears that their ability to keep work related

stressors with other EMS people help to separate from their work in EMS and avoid taking the negative emotions following a hard days work. Ultimately, their responses indicate an ability to detach and cope with their work and avoid professional debriefing services.

Despite a majority of participants who described negative views of professional debriefing services, participant #10 spoke about a desire to see more support services in the field, “sometimes you just want to be able to talk to somebody and you know you’re not able to share that, necessarily, with others.” Although he spoke about negative aspects of peer and group debriefing, such as limited privacy, he was the only participant who described a positive view of professional support services and indicated, “there needs to be something more in place to catch these things before it gets to that point [negative psychological impact]. He described that early on in his career, he experienced negative emotions from difficult calls that followed him home, but after engaging in debriefing through his supervisor, he learned to detach from the work. It appeared that his supervisor’s guidance and support helped him to understand that he was not able to save everybody’s lives when he initially joined EMS, which was something that he needed to accept. Now that he is able to cope with challenging calls himself, he is able to see how some of his younger peers with limited experience are suffering from those same challenging calls that he himself had once experienced. It was clear that he believed having access to debriefing services on an individual basis could be improved upon and remain more anonymous to protect the confidentiality of EMS personnel. Ultimately, his experience indicates that having support on an individual basis can result in improved coping abilities and remaining in the field of EMS.

**Theme #9. Shock factor.** The final risk factor that emerged from the participants in this study was the initial ‘shock’ experienced by arriving to a completed suicide. Of the twelve

participants, eight described some form of shock either from a personal perspective, or from the perspectives of family and loved ones who were also present at the scene. Some of the statements that indicated shock among participants themselves described the visual scene of the suicides. Phrases such as “First time you’ve seen somebody with their head blown off...it’s pretty wild” and “because like, if this is his first time, you’ve seen human brain hanging out of a head...” Participant #4 described a sense of uncertainty at the scene and initial feelings of shock, “I think that’s why I remember it so well...I went to the scene and I had no idea what to do.” It was clear that some participants felt an initial sense of shock at their first response to a completed suicide by the visual images that they encountered. In addition to the personal shock described among EMS personnel, some participants described the sense of shock that loved ones and other first responder’s experience. Statements such as “A lot of times when you arrive on a suicide, there’s a sense of calmness, like everybody’s kind of... everybody’s in shock I think” and “They feel like it’s a shock like it’s some abrupt thing and they never knew they thought about this or....” Those who spoke about the vicarious exposure of shock among family or other first responders described a calm and somber scene, as if everybody is too in shock to communicate.

It appeared that participants tend to “freeze up” during their first encounter with a completed suicide, as they are taken back at the images that are faced with. It was as if participants described scenes from a horror movie during their initial response with a completed suicide and that they were in disbelief about what images were in front of them. However, the sense of shock appears to decline as they gain experience and encounter more suicide calls, indicating an ability to overcome the uncertainty in the moment or “freezing up.” It was evident

that their ability to perform their roles at suicide scenes was learned with experience and through overcoming the images upon them.

**Implications.** While the next research question identifies a multitude of protective factors identified by participants to prevent symptoms of burnout or compassion fatigue, risk factors were revealed through participant's narratives. The findings of this study clearly demonstrate that the participants have experienced risk factors associated with symptoms of burnout or compassion fatigue when responding to completed suicide calls. These risk factors included taking work home, lack of understanding as to why individuals choose to harm themselves, negative emotions and symptoms of burnout, ineffective support services, and the sense of shock at completed suicides.

The literature on direct and vicarious exposure to traumatic events supports much of the lived experiences expressed by the participants. The risk of being a member in the helping profession can ultimately lead to symptoms of 'burnout,' "a syndrome of emotional exhaustion, depersonalization, and reduced personal accomplishment that can occur among individuals who do people work" (Maslach, 2003, p. 2). Various names have been given to describe these symptoms including compassion fatigue, described as the emotional response from knowledge of a traumatic event (Figley, 1995), and vicarious traumatization, the "inner experience" or providing empathy to a trauma-exposed individual (Pearlman & Saakvitne, 1995). The participants in this study did in fact express difficulty with leaving emotions and thoughts at work and allowing them to enter their personal lives. Specifically, children who were present at the scene made it more difficult to detach from their work. The lack of understanding was evident among EMS personnel as to why individuals would choose to end their lives and leave their families behind. Although symptoms of burnout were recognized from participant's

narratives, many participants described an ability to maintain their work, and even experience PTG. Posttraumatic growth is defined as the positive psychological change following a traumatic event (Tedeschi & Calhoun, 1994; 1995; Tedeschi, et al., 2007) and is also further discussed under the implications of the following theme.

As supported by the participants in this study, the literature has found that a significant percentage of calls in EMS are considered “mental disturbance calls” (Nusbaum, et al., 2006). However, the training that EMS personnel receive on mental health related issues is typically minimal in certification programs or continuing education services (Koch, 2010). I asked participants in this study to describe their training experiences on the demographic questionnaire and some of participants also further elaborated on their training through our conversations. Although I didn’t ask about specific mental health training, none of the participants revealed any specific training in mental health during their certification programs or through continuing education programs. Due to the significant amount of “mental disturbance calls” or as some participants indicated “psych” calls, part of the training in EMS certification programs could include education on mental health. This could provide information on implementing appropriate support services to family and loved ones, training on communicating and debriefing patients who are presenting with mental health related issues, and may provide ways for EMS personnel to cope with arriving to completed suicides and help to reduce symptoms of burnout or vicarious traumatization that was indicated in participant interviews.

Although there is a voluminous amount of research on implementing self-care in EMS and engaging in support services, such as critical incident stress debriefing, the participants in this study revealed negative views of professional debriefing services. The literature has also found similar results in some of the research that has been conducted on debriefing services



(Addis & Stephens, 2008; Hobbs, et al., 1996). It appeared that participants described similar thoughts regarding debriefing services, such as ineffectiveness or increased risk of vulnerability, but were supportive of those who choose to engage in such services. It appeared that those who engaged in such services did not find it beneficial or gain any positive experiences. It appeared that some participants expressed an ability to cope with completed suicides based upon personality traits. One participant stated, “you’re equipped to handle it or you’re not equipped to handle it.” Statements made by participants that indicated similar responses made me wonder whether personality characteristics exist among EMS personnel, specifically those who last in the field and those who don’t. I wondered if personality testing would be an effective tool in determining who may suffer from burnout, compassion fatigue, or vicarious traumatization among EMS personnel.

### **Research Question #3**

An area of significance for this study was to explore the question, “What protective factors are associated with EMS personnel as they respond to suicides where loved ones of the deceased are present?” The participants in this study described arriving to horrific scenes, where they described raw details of witnessing individuals who have harmed themselves in unimaginable ways. However, most participants have been in the field for more than 10 years, have learned to replace ineffective or unhealthy coping mechanisms with healthy and positive ones, and learned to detach from their work. Additionally, some participants even described positive growth from their work in EMS and their experiences with individuals who continue to present with “psych” related issues or completed suicides. The interview data revealed eight distinct themes that assist participants in maintaining their work in EMS, which includes arriving to completed suicide scenes. The themes and their implications are discussed below.

**Theme #10. Personal characteristics.** The participants in this study revealed a number of personal characteristics that seem to assist them in how they protect themselves from exposure to traumatic events in EMS. All of the participants described their own unique abilities in coping with experiences of multifaceted traumatization and encompassed how they engage in self-care.

The issue of the participant's ability to control their emotions and reactions appeared to be based on how they view their work in EMS. Some participants described the amount of experience in EMS as a contributing factor in their ability to engage in self-care and to detach from their work. Participant #1 described "the curve" in EMS where they are initially more sensitive to their work, but as time continues and experience is gained, there is a decreased emotional impact and increased "confidence" level that has been gained. Various coping mechanisms were described by participants and learned through "the curve." Participant #4 stated "Writing it all down...I would get home and I would just type it all out, type the whole call out and I felt like I was just putting it away," Participant #5 stated, "it's been able to vent through prayer," and participant #7, "meditation or relaxation." Multiple participants also described the sense of humor that is needed in EMS, "the dark sense of humor," or "make light of situations like that." Some participants described minimal impact from their start in EMS. As mentioned above, one participant described a black and white perspective of providing EMS, "I think it's either you're equipped to handle it or you're not equipped to handle it" while another stated, "But the suicides are, they've never been overly traumatic for us, for me." Both of these individuals had over twenty years of experience in EMS and appeared to be able to detach from any types of difficult calls.

It seems that the participants in this study found detachment from the work and hardening to the emotionality of suicide calls as a desirable characteristic. It was clear for some that

becoming “hardened” to these types of calls resulted in less of an emotional impact. I wondered about the relationship between debriefing services and the detachment or “hardening” of participants. Specifically, I speculated whether participants believed that engagement in debriefing would result in vulnerability and expression of emotions, meaning they were no longer “hardened” by difficult calls. If they allowed for vulnerability or expression of emotions, would this prevent them from being able to successfully do their work? These are questions that are generated by this research study and an area that can be considered for future research. Additionally, it was clear that some of the coping mechanisms that participants described were learned over time and were necessary in continuing their work. Some of these participants who identified these characteristics had indicated poor or unhealthy coping mechanisms that they had to replace with healthy coping skills to allow for emotional stability. It was clear that they learned these mechanisms on their own through their own exploring and were found to be beneficial in maintaining EMS.

What appeared to be most significant in this theme were participant’s personal experiences to losing a loved one to suicide. As mentioned before, seven of the twelve participants responded “yes” to having personal experience to suicide on their demographic questionnaire and four of those participants revealed this during the interview process. They all spoke about being familiar with the grief process to losing a loved one to suicide, such as participant #2 who stated, “I’ve been in their shoes.” Of the four participants who spoke about their personal loss to suicide, three of them described ways in which they have grown as emergency medical providers since having their own personal loss to suicide. The ways in which participants grew were described as positive, such as an ability to be more empathetic toward patients and their loved ones. Participant #3 stated, “it actually changed me. I used to go out and

judge patients, I don't do that anymore." As previously mentioned, their ability to provide care to family members appeared to be a significant role that they engaged in. Some even described going out of their way to provide "extra" care and support, such as one participant who revealed that she checks on them the following day. It was clear that understanding grief from a personal level connected them to loved ones in ways that others may not fully grasp. It appeared that this connection provides them meaning in their work and may help reduce the emotional impact of the known grief that lies ahead.

Another characteristic that was mentioned across the data collection process was the sense of excitement in providing EMS. Many participants mentioned the term "trauma junkie" and how trauma calls excite them. One participant stated that the "blood, bones, and gore" had initially pulled him into the field. Although multiple participants described that a majority of calls are not trauma-related or overly exciting, the calls that are traumatic tend to make up for the uneventful calls. Participant #12 stated, "so far it's never become boring." It is clear that EMS personnel thrive on overly exciting calls when the responsibilities are great and the moments are intense. It appears that those who enter into the field and most importantly, stay in the field, are able to maintain the emotions surrounding anxiety-provoking moments. As indicated throughout participant's interviews, responding to completed suicides are not necessarily adrenaline filled, as similar to a majority of the calls. Therefore, their ability to maintain their emotions has been described as "easier," especially after responding to multiple suicides, possibly because their emotions were never high in the first place.

Each participant described unique ways in which they have coped with their work in EMS. Only one participant stated that his way of coping was "By getting the hell out of it to be honest with ya." This individual described significant symptoms of burnout and had recently quit

his full time job in EMS and had entered into another full-time position in an unrelated field. Although he was hired PRN for another ambulance company, he had no plans to return to work in EMS. This participants experience and inability to cope with exposure to traumatic events shows that it can lead to burnout and getting out of the field.

**Theme #11. “I know the routine.”** The theme of “I know the routine” presented itself among three of the participants in this study. All three of these participants have been in EMS for at least 20 years, are all male, are at least 38 years of age, and were all providing EMS services in the same county. On the demographic questionnaire, participant #1 and #2 reported that they have arrived to at least 100 completed suicides in their years of experience, while participant #9 placed a question mark as an answer to this question and stated that he had been on too many to count. It appeared that many years of experience and many calls of completed suicides gave them this sense of “I know the routine” when it comes to responding to completed suicide calls. Although other participants had similar years of experience in EMS, these three specifically described a sense of “routine” work of responding to suicide completions or suicide attempts. It appears that these workers find a comfort and strength in their competencies around the routine of their work. Over time, they appear to have developed an ability to look at their work much as most professions, where there is an expected course of action, similar to automatic pilot. As a person outside of the world of EMS, I find it difficult to understand how watching the pain and suffering of people could become routine. It seems that viewing the work as “normal” and “routine” allows these individuals to be able to continue with their important work with minimal disturbance.

**Theme #12. “You have to let it go.”** Another protective factor that was similar to the theme, “Taking it home” under risk factors, was mentioned across the data collection process.

Eleven of the twelve participants revealed ways in which they let go of their experiences with multifaceted traumatization. This theme focused more on the ability to quickly move on from completed suicide calls. Participants highlighted the importance of leaving a call and moving on with their jobs, their lives, and ability to maintain their normal routines. Phrases such as “move on to the next one” and “you can’t take that with you.” Participants identified an ability to move on to the next call without thoughts about the last and to separate their work and personal lives, “I’ve never taken it home,” “So when I leave work I leave work there and I don’t take it home with me,” and “take off my uniform and not think about it.” All the participants seemed to have this internal sense that dwelling on their work will be debilitating. As previously mentioned, this appears to be connected to the negative thoughts about debriefing services, that talking about their experiences or holding on to them will impact their ability to do effective work. Rather, in order to protect oneself, that means one must leave their emotions at work and move on with the their day.

**Theme #13. Support.** The participants in this study identified a few support systems that help to keep them on the job. The most common form of support was the “brotherhood” described by participants as a means of venting. More than half of the participants described peer support through other EMS personnel as helpful following difficult calls. Statements made by participants included: “...someone who can get you, who’s been there, knows what we go through,” “If not, you go back to the station and you talk about it with your partner. You do whatever you have to do get your mind off of it...” and “I’ll the keep conversation for between friends in EMS.” This sense of “brotherhood” references back to other themes that were previously identified, specifically negative thoughts about professional debriefing services and how conversations are kept within EMS. The ability to communicate with other paramedics or

EMT's provided a platform for emotional recovery after a long day. Another form of support identified among participants was their own family and loved ones. Participant #4 stated, "Just knowing that even when I'm on a call, just knowing that he [her husband] knows that I can do it, really makes a difference," and another participant stated, "hanging out with the kids is a good one." Lastly, two of the participants identified professional services as beneficial, although only one participant indicated that these services were provided for difficulties with EMS. The one participant described engaging in professional counseling services, although for reasons unrelated to her work in EMS, "I don't know how I made it through that, if it wasn't for my therapist." Another participant was in favor of debriefing services, although as mentioned above, most of the participants did not believe such services were beneficial, "You kind of vent to each other which is good, but at the same time, sometimes a third party is better... [debriefing teams]."

A review of support services including both internal (peer support, support from supervisors) and external (professional debriefing teams) were reviewed in the literature in chapter two of this study. Some of the literature identifies positive findings for professional debriefing teams, such as critical incident stress debriefing, while other studies indicated negative or even harmful effects from debriefing. A majority of participants in this study reported that they have declined professional debriefing services that were offered to them or found them to be ineffective or harmful. The literature supports these negative statements of debriefing services, suggesting that there are risks of re-traumatization (Prati & Pietrantonio, 2010), poorer psychological health (Small, et al., 2000), or higher rates of developing symptoms of PTSD (Addis & Stephen, 2008). Overall, it appears that the participants in this study are able to maintain their emotions and maintain their job, without engagement in professional debriefing

services. Their preference to remain conversations between EMS personnel appears to be more beneficial and “enough” to get them through.

**Theme #14. Detachment.** The participants in this study indicated ways in which they detach from their work in EMS. All but one interview contained at least a mention of detaching from their work or from developing an emotional impact of seeing a completed suicide with the loved ones of the deceased present. The ability for participants to detach from their work appeared to be a necessity for longevity in EMS.

Many participants described an ability to detach their emotions from their work. Some indicated that this took time to learn, while others described having this ability from their start in EMS. The following phrases were stated by some of the participants regarding their response in arriving to a completed suicide scene and their experiences with vicarious traumatization: “EMS people are EMS people because we leave it there and we can totally separate ourselves from it,” “So you kind of have to separate yourself,” “I can say for the most part I don’t get involved,” “It just stays there but you block it off so that it doesn’t bother you,” “I feel you get that desensitization throughout the years,” and “disconnect.” Through conversations with participants, I noticed that specific words were used to describe the attachment from their work, “cold,” “hardened,” “numb,” “compartmentalize,” “accustomed,” and “insulated.” Through conversations with participants, a sense of detachment was also revealed in the sense that the “The deeds done already” by the time they arrive to the scene. Participant #1 stated “Yeah, the decision, whatever they’ve done, that decision was made long before, that decision had nothing to do with us. So you know I honestly don’t get caught up in any of it.” Participant’s responses indicated that they all have unique ways in which they detach from their work through a separation of emotions. The ability to detach appears to be necessary in order to function



effectively as a paramedic or EMT. Detachment is a common coping mechanism among first responders and is supported in the literature (Adams, Anderson, Turner, & Armstrong, 2011). In this study, it appears to be a key survival tactic for participants in order to remain separated from their emotions. By remaining detached, participants reveal an ability to maintain their work in EMS and function effectively on a personal and professional level.

The last pattern of detachment was the sense of dehumanization. Some participants described dehumanizing from the patient, such as participant #12 who stated “they’re just an airway until you get them to the hospital” and “you get so focused on the procedure and the thing that you need to do to help them that you really distance yourself from the person,” while participant #5 stated, “I can’t even tell you what any of these people really look like.” Although these statements were minimal, it appeared to be a protective factor for a few of the participants. Their ability to see patients as a medical procedure, rather than a person, indicates an ability to detach any emotional connection to them and appears to be an effective coping mechanism among some.

**Theme #15. Acceptance.** Four of the participants identified acceptance as an ability to protect themselves from their work. It appeared that acceptance as a protective factor has been learned over time for these participants and that they come to the realization that traumatic events will continue to happen and they continue to respond to them. Phrases that indicated acceptance: “You see what society is, I mean 20 years ago, I was 18 years old and I was, I wanted to save everybody on the planet you know what I mean, but 20 years later, it’s... you accept it” and another participant stated, “I think you just accept it.” It appeared that acceptance was a key factor in coping with responding to completed suicides. It was clear that participants have accepted the fact that they will never be able to “save” everybody. Additionally, people will

continue to present with “psych” related issues and choose to take their own lives. They understand that being a first responder entails calls that they wish they could avoid, but ultimately they must respond to all types of calls including “psych” related calls and completed suicides. Their ability to “accept” undesirable calls appears to be critical in maintaining one’s job as an emergency medical provider.

**Theme #16. Family becomes patients.** This study looked at participant’s experiences of vicarious exposure at a completed suicide scene where they experience the event through the eyes of loved ones of the deceased. A pattern that emerged among participants was the desire to help care for family and loved ones at the scene of a completed suicide call. Half of the participants indicated ways in which family and loved ones become patients themselves. They described ways in which they provide support to loved ones, “you’re trying to console them” and “grief counselor.” Others mentioned that family often become the actual patient and medical interventions are provided at times, participant #3 indicated, “grandma falls down with chest pain or shortness of breath or something... take her down to the hospital.” They indicated that family and loved ones are just “as important” as the actual patient. Four of the six participants who described their desire to help family members and loved ones also noted having personal loss to suicide on the demographic questionnaire. Throughout the interview processes, some of the participants who described having personal loss to suicide had made comments that they have been in the shoes of family and loved ones at these scenes. It appears that having personal loss to suicide has created a greater understanding of the initial shock and grief that loved ones at the scene experience. As mentioned earlier, it also appears that providing support and services to family and loved ones gives them a role to engage in at a completed suicide call and additionally, gives them purpose at the call. Their typical role of providing emergency medical services is

useless and their focus on family and loves ones gives them a sense of satisfaction that they have “helped” someone.

**Theme #17. Their misfortune made me realize my life was pretty precious.** The last protective factor that emerged from participant’s narratives was the realization that their own lives were valuable and precious. Although it was not a common theme among a majority of participants, three of the participants indicated ways that responding to suicide calls and experiencing vicarious traumatization has changed the ways they think about life, “Makes you value your life” and “I think how your life could change.” This appeared to be a protective factor among these participants as they have made conscious efforts to make the best out of each day. One participant stated “...how I look at my relationships with my friends and my family...” These statements appeared to be an indicator of PTG, as PTG signifies personal strength, a sense of spirituality, an improved appreciating and satisfaction of life, relational intimacy, and an awareness of life possibilities (Dekel, et al., 2012). It was clear that participants value their time and relationships with others due to their exposure to tragedy. Some indicated ways in which they changed as a person, such as the way they treat others as they know that life can be taken away in an instant.

**Implications.** The participants in this study supported some of the findings in the literature review that relate to the ability among EMS personnel to cope with direct and vicarious traumatic experiences. The participants identified ways in which they have coped with multifaceted traumatization in their years of experience such as through personal characteristics, support, detachment, empathy, and acceptance. Multiple ways of coping were indicated among participants and all participants reported at least one way in which they cope with multifaceted traumatization.

All of the EMS personnel in this study, except one participant, demonstrated an ability to continue functioning effectively in their work. Although many participants who identified protective factors also described risk factors (reviewed in the second research question), it appeared evident that they were able to continue work through use of these protective factors. All but one participant has hopes to continue in EMS or in another related field as some had indicated they were currently students in other medical fields (e.g. nursing). Their sense that the completed suicide calls were a responsibility that they have as an EMS provider, as well as a responsibility of caring and supporting family and loved ones at the scene, was an integral part of providing EMS.

What appeared most significant was the “brotherhood” in EMS and how EMS personnel really stick together. Many participants described peer debriefing through chats after difficult calls or making jokes around the office. Support among other paramedics or EMT’s appeared to be essential in maintaining the work they do. Support or debriefing services in supervision did not appear to be a common theme among participants in this study as only one participant indicated an experience of supervisor debriefing following a difficult call. This is also indicated in the literature, as Regehr, et al., (2002) concludes that minimal debriefing is provided from employers. However, other research reports that debriefing from supervisors can be common (Halpern, et al., 2008).

As previously mentioned, there is minimal literature on first responders arriving to completed suicide scenes. The study by Koch (2010), which was briefly reviewed in chapter two of this study, focused on the police officers and their experiences of responding to completed suicide scenes. The study concluded ways in which police officers detached from their emotions when arriving to completed suicides. The coping mechanisms identified by police officers in this

study included adherence to police roles, blocking feelings, humor, anger, faith, telling stories, depersonalization, investing or divesting, engaging or disengaging from suicide survivors, and preparedness/alertness/adrenaline (Koch, 2010). Some of these mechanisms were also revealed in this study and were indicated under the above themes.

#### **Research Question #4.**

Central to the discussion of EMS and responding to trauma is the question, “How do EMS personnel make meaning of their experiences of responding to completed suicide calls with the presence of loved ones of the deceased?” A majority of participants for this study revealed ways in which they describe the meaning that providing EMS gives them and what their role as an EMS personnel does for them. The following paragraphs are a review of this theme and its implications for the work.

**Theme #18. What I get from the work.** Through examination of the interview data, many of the participants identified ways that they make meaning of their experiences and work in EMS. Many participants spoke about EMS as part of their identity, “I eat, sleep, and breath this. I honestly, this was my calling.” Some participants in this study started in EMS in youth programs during adolescence, while others started soon after high school. Many participants who have been employed (or volunteered) in EMS for many years indicated continued enthusiasm, such as participant #1, “I don’t have any less enthusiasm now than I did before” and “It’s engrained in me, it’s without a doubt who I am.” Participant #2 spoke about EMS in his family, “My dad was an assistant chief for 22 years. I think I might have been conceived in the fire station. I mean...my brother and I are...he’s as active as I am. It’s all I’ve ever done.” It appeared that EMS personnel in this study reveal EMS as part of their identities. Their responses

indicated that their roles as paramedics or EMT's have been engrained in many of them since childhood and they have hopes that it will continue with them for the remainder of their lives.

Some participants described the "love" they have for the field and how dedicated they are to continue to provide emergency medical services. Of the twelve participants in this study, nine of them identified the sense of reward they receive in providing emergency medical services. Some of the responses provided by participants were not directly related to the reward they receive arriving to a completed suicide call, but were more toward the reward from providing EMS in general. Some participants identified success as a paramedic or EMT, which provided a sense of reward, such as participant #2 who stated, "I'm good at it" and participant #7, "I'm pretty good at it, so I like that about it." Others indicated a reward from helping their patients, participant #4 who described reward from helping family members, "just being able to go in and say I know what to do and taking that weight off the family members, I love that about my job" and participant #11, "that you actually save and help people because it gives you meaning." It appears that being successful in EMS presents itself as a reward. Their ability to take care of others effectively gives them a sense of meaning in their lives personally and professionally. Participants indicated that it "feels good" to help people and save lives.

**Implications.** The participants in this study supported some of the findings in the literature on coping with trauma and experiencing PTG. As previously described, PTG is defined as the positive psychological change after experiencing a traumatic event or a major life crisis (Tedeschi & Calhoun, 1994; 1995; Tedeschi, et al., 2007). The literature on PTG and EMS has indicated that a majority (up to 99% of EMS personnel) report having a positive change following a traumatic work event (Shakespeare-Finch, et al., 2003). Although none of the participants described specifically a positive psychological change after responding to a

completed suicide call or through experiencing vicarious traumatization, the enjoyment, reward, and sense of identity can be considered as PTG.

**Table 15. Themes Delineated from the Research**

<b>Theme #1</b>	Lived body
<b>Theme #2</b>	Lived space
<b>Theme #3</b>	Lived time
<b>Theme #4</b>	Lived relationship
<b>Theme #5</b>	Taking it home
<b>Theme #6</b>	Why?
<b>Theme #7</b>	Negative emotions/burnout
<b>Theme #8</b>	Minimal coping and support
<b>Theme #9</b>	Shock factor
<b>Theme #10</b>	Personal characteristics
<b>Theme #11</b>	“I know the routine”
<b>Theme #12</b>	“You have to let it go”
<b>Theme #13</b>	Support
<b>Theme #14</b>	Dehumanization/detachment
<b>Theme #15</b>	Acceptance
<b>Theme #16</b>	Family become patients
<b>Theme #17</b>	Their misfortune made me realize my life was pretty precious
<b>Theme #18</b>	What I get from the work

### **Limitations of the Study**

This qualitative study used 12 participants who identified as paramedics or EMT's and were currently employed or volunteered in various ambulance companies. The participants in this study were selected based upon their experiences with responding to completed suicides where loved ones of the deceased were present. I chose to limit participation to paramedics and EMT's as opposed to other first responders, due to the lack of research on paramedics and EMT's responding to completed suicides. Therefore, this study is not necessarily generalizable to all EMS personnel who respond to completed suicide scenes. In addition, the demographic questionnaire indicated minimal diversity with race/ethnicity among participants. All participants identified as Caucasian, except one individual who did not respond to this question on the demographic questionnaire. This racial/ethnic makeup is indicative of the general population of the area in which the study was conducted. The participants were recruited from only two states, Ohio and Pennsylvania. The participants did however come from rural areas and small towns, as well as urban areas and larger cities within these states. However, the study may not accurately reflect the experiences of other EMS personnel from other geographical locations. Lastly, the study included only 12 participants and does not represent all employed or volunteer paramedics and EMT's.

Another limitation of the study is the duration of experience among the participants. I chose to select participants who had more than one year of experience to increase the likelihood of responding to multiple completed suicide calls, however this may have eliminated participants who have less than one year of experience, but have responded to multiple suicide calls. It may have been interesting to see the experiences described by paramedics and EMT's who are fresh into the field. All of the participants who contacted me or who were agreeable to participation



had at least seven years of experience, with half (six participants) having at least 20 years of experience in EMS, resulting in a sample of seasoned EMS personnel. It could be that those who chose or agreed to participate are those individuals who now experience less of an emotional impact from responding to suicide calls and are more willing/able to talk about their experiences.

Lastly, I may have been a limitation in this study through my own biases and presuppositions in conducting interviews and explicating the data. Although I do not experience direct exposure to suicide calls in my work as a therapist, I have experienced the loss of clients to suicide, as well as hearing many of my client's discuss the grief and trauma of losing a personal one to suicide. These experiences and its effects may have influenced the data collection process and interpretation of data. Although it is not possible to completely mitigate my own biases and presuppositions, I attempted to eliminate them through the analytical notes I took following interviews and through consultation with my committee members. In addition, I may have influenced the responses of individuals who participated in this study. It could be that some individuals may have felt pressured to answer in a way that they believed I expected them to. Also, some participants may not have been completely honest about the impact that multifaceted traumatization has had on them. Despite a thorough review of confidentiality with each participant and explanation that all identifying information would be removed, some may have been concerned that the information they provided would be revealed through this study.

### **Implications for the Field**

This study has significant implications for the field of counseling, including counseling education and supervision. Students in master's level counseling programs are enrolled in core classes to help prepare them in becoming professional counselors. Despite the minimal trauma courses in counseling curriculums (Gere, Dass-Brailsford, & Hoshmand, 2009), the results of

this study could be incorporated into existing trauma courses, to educate students on the impact of multifaceted traumatization among first responders. Additionally, the results from this study can provide counselors with knowledge on working with EMS personnel in various settings including outpatient services and crisis response services. Lastly, counseling supervisors who work with counselors can use this information to educate their supervisees on the impact of trauma among EMS personnel.

### **Implications for Future Research**

From the data collected in this interview, a number of areas presented for future research. Although many participants described a sense of feeling “hardened” or “cold” from the work in EMS and specifically through discussion of responding to completed suicides, some participants described experiences of personal growth. It would be beneficial to explore the PTG that participants experience in their role as EMS personnel and in their experiences of responding to suicide calls where the loved ones of the deceased were present. Specifically, it appeared that some participants who identified having personal loss to suicide were able to personally and professionally grow as an EMS provider and gain a sense of empathy with their patients and loved ones. To conduct a study on PTG may provide an awareness of what can assist other EMS personnel to grow in the work that they do.

A second area that presented for future research was the experience of providing emergency medical services to a patient who has attempted suicide. Through my discussions with participants, many described their experiences of responding to calls of suicide attempts, in addition to their role of responding to completed suicide calls. Many described difficult scenes where individuals have attempted suicide and have “worked” them until they arrive at the hospital. One participant pondered about saving the life of somebody who didn’t want to live and

who had verbalized this to him during the call. He stated that he finds himself “forcing them” to stay alive following a significant suicide attempt. This may also be an area of research to explore, specifically how EMS personnel describe their experiences of helping to save a patients life who does not want to live.

### **Questions Generated by Research**

A number of questions have emerged directly from this study:

- Does the length of experience as a paramedic or EMT improve the ability to manage or cope with the emotional impact of responding to suicide calls with the presence of loved ones of the deceased?
- Do the experiences among paramedics/EMT’s differ from other EMS personnel or first responders?
- Does participation in this study and reflection about experiences of responding to suicide calls make participants think differently about their role as an EMS personnel?
- Does working in a smaller town where EMS personnel reside impact the work they do?
- Does having recurrent calls with individuals who attempt suicide result in higher rates of burnout?
- Does arriving to suicide attempts/suicide completions of a known individual create a greater emotional impact?
- How do EMS personnel make sense of seeing an individual at a later time who they had previously helped to save following a suicide attempt?
- Does having personal loss to suicide impact the work as an EMS personnel?

- Does having personal loss to suicide impact the way you care for loved ones of the deceased at a completed suicide call?

### **Conclusion**

The purpose of this study was to explore the lived experiences of paramedics and EMT's who responded to calls of completed suicides where the loved ones of the deceased were present. These EMS personnel identified experiences of direct and indirect traumatization as a result of their work. The study provided an in-depth look at how these EMS personnel describe both the positive growth they experience, as well as the negative consequences, and how they sustain their work in EMS.

A total of twelve EMS personnel participated in this study through individual semi-structured interviews. From the discussions of their experiences and how they perceive their work in EMS with responding to completed suicides with the presence of loved ones of the deceased, 18 themes emerged. These themes revealed that the paramedics and EMT's in this study do experience a negative psychological impact. Some participants described experiencing negative emotions that relate to symptoms of burnout, compassion fatigue, and vicarious traumatization. The paramedics and EMT's in this study were also able to identify many characteristics within themselves that mitigate the negative emotions and help them to find meaning in their job and detach from negative consequences of their work. These characteristics sustain the work they do in EMS. Some characteristics of posttraumatic growth were also identified in participant's narratives as a direct result of helping others.

The findings of this study emphasize the need for additional areas of focus among EMS personnel and the combination of direct and vicarious traumatization of responding to completed suicide calls. More focus on multifaceted traumatization may help to identify better support or

debriefing services. Additionally, an improvement in this work could reduce the psychological impact or negative experiences that EMS personnel describe.

This study provides a unique look at multifaceted traumatization among EMS personnel, which has not previously been examined. It looks at the direct and vicarious exposure of EMS personnel and how they make sense of the work they do when they directly respond to suicides and the secondary exposure of loved ones at the scene. EMS personnel often work long hours for little pay and are undervalued in emergency medicine. It is hoped that the information from this study and the implications for future research will lead to further exploration of this phenomenon and providing trauma informed care among EMS personnel.

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## Appendix A: Recruitment Letter



## Recruitment Letter

Dear Participant:

I am a doctoral candidate under the direction of Debra Hyatt-Burkhart, Ph.D. in the Department of Counseling, Psychology, and Special Education at Duquesne University. I am conducting a research study to better understand EMS personnel's experiences when responding to suicides where loved ones of the deceased were present at the scene. This research is partial fulfillment of my studies for a doctoral degree in counselor education and supervision.

I invite individuals to participate in this study who meet study parameters (identify as an employed or volunteer paramedic or EMT and have worked or volunteered for at least one year, have responded to at least one suicide where loved ones of the deceased were present, and are over the age of 18). To participate, you will be asked to complete a demographic questionnaire and we will meet for an approximate one-hour individual interview to talk about your traumatic exposure experiences as an EMS worker. After completion of the interview, you will have the opportunity to review the transcript from our interview and make any corrections if you identify any errors.

Your participation in this study is voluntary and you may withdraw from the study at any time, without any penalty. The results of this study may be published, but your identity is kept anonymous. There is minimal risk involved in your participation of this study. The findings from this study may not directly benefit you as an EMS worker but your participation can help researchers gain a better understanding of the traumatic exposure experiences of EMS personnel.

If you are interested in participating in this study, please contact Mallory Wines, M.S.Ed., LPC at 330-708-9683 or [schellm1@duq.edu](mailto:schellm1@duq.edu) to confirm an interview time and location and to answer any questions you may have. The consent form is attached for your review. We will review the consent form again at the time of the interview and you will be asked to read and sign the consent form prior to the interview.

If you have any questions concerning this research study or your participation in the study, please contact me, Mallory Wines, M.S.Ed., LPC, at (330) 708-9683 or [schellm1@duq.edu](mailto:schellm1@duq.edu), or Dr. Debra Hyatt-Burkhart at (412) 396-5711 or [hyattburkhart@duq.edu](mailto:hyattburkhart@duq.edu).

This study has been approved by Duquesne University Institutional Review Board.

Sincerely,

Mallory Wines, MEd, LPC

## Appendix B: Recruitment Flyer



DUQUESNE UNIVERSITY  
600 FORBES AVENUE ♦ PITTSBURGH, PA 15282

**Be part of an important research study:**  
***Understanding the experiences of EMS personnel who responded to suicides where loved ones of the deceased were present***

- Are you at least 18 years of age?
- Have you been an employed or volunteer paramedic or EMT for at least one year?
- In your duties as an EMS worker, have you responded to a suicide where loved ones of the deceased were present?

If you answered YES to these questions, you may be eligible to participate in a research study titled:

***Multifaceted Traumatization: Direct and Vicarious Exposure of EMS Personnel who Responded to a Suicide Where Loved Ones of the Deceased were Present.***

I am seeking interviewees to participate in one interview to better understand the experiences of traumatic exposure in your daily duties as a paramedic or EMT. To gather this information you will be asked to complete a demographic questionnaire and answer interview questions focusing on your thoughts related to responding to suicides where there was loved ones of the deceased present (approximately 1 hour).

Interviews will occur in a remote location, such as a private room in a local library or university. Your participation in this study is confidential. I will explain the steps taken to protect your privacy and anonymity prior to beginning the study.

**For more information about this study or to volunteer to participate please contact me at:**  
Mallory Wines, MEd, LPC (PhD Candidate)  
Duquesne University, Department of Counseling, Psychology, and Special Education  
[schellm1@duq.edu](mailto:schellm1@duq.edu) or 330-708-9683 (private email or personal cell phone)

## Appendix C: Informed Consent



# DUQUESNE UNIVERSITY

600 FORBES AVENUE ♦ PITTSBURGH,  
PA 15282

## CONSENT TO PARTICIPATE IN A RESEARCH STUDY

- TITLE:** Multifaceted Traumatization: Direct and Vicarious Exposure of EMS Personnel who Responded to a Suicide Where Loved Ones of the Deceased were Present
- INVESTIGATOR:** Mallory Wines, M.S.Ed, LPC Doctoral Candidate  
Duquesne University  
School of Education  
Department of Counseling, Psychology, and Special Education [schellm1@duq.edu](mailto:schellm1@duq.edu)  
330.708.9683
- ADVISOR:** Debra Hyatt-Burkhart, Ph.D., LPC, ACS Assistant Professor  
Duquesne University  
School of Education  
Department of Counseling, Psychology, and Special Education [hyattburkhartd@duq.edu](mailto:hyattburkhartd@duq.edu)  
412-396-5711
- SOURCE OF SUPPORT:** This study is being performed as partial fulfillment of the requirements for the doctoral degree in The School of Education; Department of Counseling, Psychology, and Special Education at Duquesne University.
- PURPOSE:** You are being asked to participate in a research project that seeks to investigate the multifaceted traumatization of EMS personnel who arrive to a suicide where loved ones of the deceased are present. Multifaceted traumatization is defined as the exposure of both direct and vicarious traumatic experiences. In order to qualify for participation, you must be an employed or volunteer EMS personnel and meet the study parameters (identify as an employed volunteer paramedic or EMT and have worked or volunteered for at least one year, have responded to at

least one suicide where loved ones of the deceased were present, and are over the age of 18).

**PARTICIPANT  
PROCEDURES:**

To participate in this study, you will be asked to: complete a brief demographic questionnaire, participate in one individual interview at a secluded location for approximately one hour; discuss your experiences of responding to mental disturbance calls and completed suicides with presence of loved ones of the deceased in your role as an EMS personnel, in order to participate in this project. All interviews will be audiotaped and transcribed.

These are the only requests that will be made of you.

**RISKS AND BENEFITS:**

Given the nature of this study, there is no apparent risk to participation. As the participants will be engaging in a conversation focused on their day-to-day experiences of their job or volunteer work, there are no expected negative risks from participation. There may be feelings of discomfort as a result of talking about emotional experiences, however these feelings are not expected among participants, as these circumstances are routine in the daily world of EMS work. The findings of this study may not directly benefit you as an EMS worker, but your participation can help researchers gain a better understanding of the traumatic exposure experiences of EMS personnel.

**COMPENSATION:**

There will be no compensation for this study.

Participation in the project will require no monetary cost to you.

**CONFIDENTIALITY**

Your participation in this study and any personal information that you provide will be kept confidential at all times and to every extent possible.

Your name will never appear on any survey or research instruments. All written and electronic forms and study materials will be kept secure. Your response(s) will only appear in summarization of report findings. Confidentiality will be maintained with the use of audiotapes. All materials related to the study will be stored in a locked cabinet to which only the investigators have access. Any electronic data will be password protected. This password protection will be

used on all flash drives and other external memory devices. Any study materials with personal identifying information and transcribed interviews will be maintained for five years after the completion of the research and then destroyed.

**RIGHT TO WITHDRAW:**

You are under no obligation to participate in this study. You are free to withdraw your consent to participate at any time by informing the investigator that you wish to withdraw via email or at the interview. Any data collected prior to withdraw will be destroyed and not used in this study.

**SUMMARY OF RESULTS:**

A summary of the results of this research will be supplied to you, at no cost, upon request.

**VOLUNTARY CONSENT:**

Your participation in this research study is voluntary, and you do not have to answer any questions that you do not want to answer. You may choose not to participate. If you decide to participate, you may withdraw at any time. If you decide not to participate in this study, or if you withdraw from participating at any time, you will not be penalized.

I have read the above statements and understand what is being requested of me. I also understand that my participation is voluntary and that I am free to withdraw my consent at any time, for any reason. On these terms, I certify that I am willing to participate in this research project.

I understand that should I have any further questions about my participation in this study, I may call Mallory Wines (330) 708-9683 or Dr. Debra Hyatt-Burkhart (412) 396-5711 or if I have any questions regarding protection of human subject issues, I may call Dr. Linda Goodfellow, Chair of the Duquesne University Institutional Review Board, at (412) 396-1886.

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Participant's Signature

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Date

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Researcher's Signature

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Date

## Appendix D: Demographic Survey



## Demographic Questionnaire

1. What is your job title?

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2. What is your training?

---

3. What is your certification or licensure?

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4. How many years of experience do you have in this position?

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5. Approximately how many suicides have you responded to in your position?

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6. Do you have any personal experience with suicide of a loved one?

Yes \_\_\_\_\_ No \_\_\_\_\_

7. What is your age?

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8. What is your Ethnicity?

---

9. Gender

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